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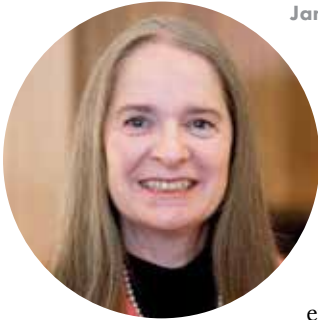
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Editorial



Jane Lochrie, MD

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care act into law. Since that time there has been an impetus to build the necessary infrastructure to carry out the immense expansion of healthcare coverage.

This has resulted in a push for more value, better outcomes, greater convenience more access; all for less cost.

Innovations in healthcare delivery has seen an explosion of these innovations designed to improve life expectancy and quality of life, including artificial intelligence, point of care diagnostics, social media online communities, retail clinics and telehealth. This issue of Worcester Medicine explores the ways that the Worcester community is working to meet the health care needs of its population, including those who do not have insurance.

In the first article Shlomit Schaal, MD, PhD reports the U Mass Memorial Eye Center has been transformed over the past three years with a focus on the Four T's. 1) Teams are empowered to voice their ideas 2) Waiting time has a goal of less than 5 minutes 3) Technology – the equipment has been 100% upgraded 4) Transformation – the culture has been aligned to the culture and strategic goals of the organization. The Eye Center is committed to providing an exceptional experience for patients and their referring physician.

David Wilner, MD, FACP, AGSF whose name you might recognize from past contributions once again lends us his expertise by describing the Program of All-Inclusive Care for the Elderly (PACE). Adults aged 55 and older who meet the requirements of nursing home level of care can elect to live at home and receive their care for an 11-member interdisciplinary health care team who maximize patients' functional status and promote caregiver well-being.

Sheilah Dooley, RN, BSN, MS explains the importance of recognizing trauma in the lives of the patients that Pernet Family Health Service assist. Some of the people have criminal histories, struggle with addiction and mental health issues, are victims of abuse and have language barriers and/or immigration issues. Most have experienced some type trauma. Pernet's mission is to provide health care and support disadvantaged families and to revitalize the spirit of those degraded by poverty. The agency has received a grant to implement the practice of Trauma-Informed Care that she describes in her article.

An update on the Care Mobile is provided by Michelle Muller, MSM, FNP-BC. The Care Mobile program is based on a model of providing innovative, community-based medical and preventive services onsite in socioeconomically disadvantaged neighborhoods and school settings. They provide physical exams, semi-urgent visits, lab testing, care for chronic illnesses, immunization, dental cleanings and screenings, fluoride treatments and both health and dental education.

The role of nursing in the digital age is described by Theresa Rincon, RN, PhD, CCRN-K, FCCM. Nurses and nurse practitioners work in tele-ICU teams and provide services in several ways: surveillance that identifies patients who are deteriorating and require intervention, mentoring fellow nurses, responding to clinical alerts, leading best practice rounding and collecting important data for quality reporting. Cassandra Godzik, MSN, RN, PMHNP-BC explains tele-psychiatry that allows psychiatric clinician to manage multiple patients in different locations. In addition, tele-psychiatry allows patients to videoconference with their clinician in the comfort of their own home, reducing the cost of transportation and travel time and affording less missed time from work and family.

Innovations in medication therapy management is discussed by Kristen Milenki, PharmD, Karl Mereus, PharmD, MS and Helen Pervanas, PharmD. Medication Therapy Management (MTM) is defined as a service or group of services that optimize therapeutic outcomes for individual patients. The goal of MTM is to improve quality of life by improving drug use, optimizing clinical outcome while reducing risk of adverse events and health care cost.

The student perspective is provided by Miriam Goldberg who describes her research that she started in the MIT Media Lab.

She is working on a communication system that can be accessed by ICU patients and patients with severe motor impairments.

This issue also contains the winning pieces from the 2019 Massachusetts Medical Society Creative Writing Expo. Please enjoy "Creeping Charlie" by Ronald Pies, MD and "The Visitor" by Paul Berman, MD.

I am excited to introduce a new feature article, "Worcester Medicine Looks Back: News from the Archives" that is starting with this issue and is authored by Dr. B. Dale Magee. Dr. Magee will be scouring the archives to find a relevant article that was previously printed in Worcester Medicine. As always, don't forget to read As I See It, Legal Consult, Restaurant Review and Society Snippets.

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Four T's Translate to Exceptional Patient Experience at UMass Memorial Eye Center



Shlomit Schaal, MD, PhD

The UMass Memorial Eye Center has transformed itself with technology and a top-rated team that keeps its focus on providing patient care in a timely manner.

An exceptional patient experience is the number one goal of every member of the UMass Memorial Eye Center team.

Each member of the department's talented and like-minded caregivers – from front-line office staff and technicians to physicians and scientists – were hand-picked for the expertise they bring to bear for our patients.

A positive patient experience is what drives every step of the decision making at the Eye Center with a focus on The Four T's: Team, Time, Technology and Transformation.

Team: As we began our department's transformation in 2016, the first goal was to engineer a dynamic team of caregivers. Every new and existing team member knows that every member of the team is critical to the patient and responsible for the patient outcome. Everyone is empowered to share their voice and ideas to care for our patients. We're always looking for ways to improve and it takes every team member to make those changes.

In the most recent caregiver and physician engagement surveys, the Department of Ophthalmology and Visual Sciences received the highest scores throughout the system, which is credited to the fact that everyone on the team knows that they can contribute and that their ideas are listened to and valued. This work has resulted in Eye Center being named as "Innovator of the Year" in 2017 and has been a "Sweet 16 Innovators" finalist every year since.

Time: We understand that time is the most valuable thing to us as human beings. We can't make more time, but we can make sure we and our patients aren't wasting it. With a goal of limiting patients' wait time to no more than five minutes in any area of the clinic, the Eye Center is consistently studying and improving patient flow to reduce wait times.

Whether it is a patient who needs to be seen urgently or a referring physician who needs to send a patient to our clinic, time is precious to all of us. In addition to creating walk-in clinics, the Eye Center created specialized clinics that allow physicians to increase the number of patients they're able to see by streamlining care and focusing on one service for an entire session. A stellar example is the Diabetic Eye Disease Screening Clinic, which increased patient preventative diabetic eye care from 22% to 95% since 2017.

Technology: Since 2016, the Eye Center has upgraded 100% of its equipment. Knowing that the quality of eye care relies on our ability to recognize patterns in the eye, the level of care we're able to provide is dependent on having the latest technology.

The UMass Memorial Eye Center has new technology at all clinics, including a new wide-field imaging machine. The team is performing some fascinating research in the field of artificial intelligence (AI) and its role in predicting illnesses such as high blood pressure, stroke, multiple sclerosis (MS), diabetic retinopathy, macular degeneration and sleep apnea. All equipment in the eye operating rooms has been replaced with new technology so all surgeons can use the latest and most advanced surgical techniques in caring for patients.

Transformation: The shift in culture at the Eye Center is the primary factor behind the clinic's tremendous transformation. We're continuously progressing and aligning ourselves to the culture and strategic goals of the organization. As a proponent



of the UMass Memorial Lean Visual Management System all Eye Center team members are encouraged to share their ideas for improvements.

As a testament to the respect we've been able to garner during the past three years, the department is currently ranked the second in New England for research dollars and first at the University of Massachusetts Medical School for research grant funding out of all surgical departments. This puts the Eye Center at the center of technology and cutting-edge research that helps deliver the best care for our patients.

The Bottom Line: With a focus on high-quality care, respect and communication, the UMass Memorial Eye Center is committed to providing an exceptional experience for patients and their referring physicians.

The relationship with referring physicians is important to providing patients with the best care. It is viewed as a partnership and the Eye Center team is excited to join them in taking excellent care of their patients who are going to be seen in a timely manner by competent, caring individuals who have access to the latest technology. Patients will receive specialized care in concert with the referring physicians. The patient is at the center of our universe.

About the UMass Memorial Eye Center

The UMass Memorial Eye Center has three locations:

- UMass Memorial Medical Center – Hahnemann Campus, 281 Lincoln Street, Worcester
- UMass Memorial Medical Center – University Campus, Ambulatory Care Center (ACC), 55 Lake Avenue North, Worcester
- UMass Memorial Medical Group at Northborough Crossing, 333 Southwest Cutoff, Northborough

Walk-in appointments for urgent cases are available at the Hahnemann and ACC locations. Next-day appointments can be scheduled at all three locations. For referrals, physicians should call 508-334-6855. Patients should call 855-UMASS-MD (855-862-7763).

The Department of Ophthalmology and Visual Sciences offers monthly Vision Seminars on the third Thursday of each month at 5:30 pm. This program is open to all. See a list of upcoming events on the department's Medical School web page.

Shlomit Schaal, MD, PhD, Chair, Department of Ophthalmology and Visual Sciences, UMass Memorial Medical Center and Professor, University of Massachusetts Medical School

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The Program of All-Inclusive Care for the Elderly

David Wilner, MD, FACP, AGSF



Some may consider The Program of All-Inclusive Care for the Elderly (PACE) to be too old a program to be considered innovative- yet it is the ultimate in state-of-the-art care! It removes insurance restrictions and allows the directly involved health care workers to decide on which treatments and interventions to provide. This model promotes (actually requires) robust interaction among multiple health disciplines and uses participant identified goals to create patient specific health care plans of care. There are no or limited barriers to provide the interventions and services the care team thinks are appropriate. And the 11-member team of health care professionals is available without obstacles to their interactions. And it's not too good to be true! Wow - isn't that what we all want when we provide care for our patients?

The PACE model of care was developed in the 1970s and 1980s in the Chinese community of San Francisco to help their older adults needing long term supports and services remain in the community and avoid nursing home placement. Working with Medicare and Medicaid as a demonstration project into the 1990s, it became a permanent program of Medicare in 2006 when the Center for Medicare and Medicaid Services (CMS) published regulations. Adults aged 55 and older who meet their state's requirements for nursing home level of care can elect to receive their care through a PACE program instead of accessing or being admitted to a nursing home.

Plenty of older adults with functional impairment are struggling by themselves or with family members to identify, provide, and coordinate care. Traditional medical care relies on reactive care to exacerbations of chronic conditions and new acute events. And traditional payment models require one to have such an event to intervene with services such as home nursing care, physical and occupational therapies, and home visits by nurses, doctors, nurse practitioners, physician assistants, social workers, and home health aides. Access to long term support and services (LTSS) is important to help our patients maintain as much independence as possible, decrease caregiver stress, and interrupt the cycle of acute inpatient stays, discharge to SNF, then a return home with the same chronic conditions that leads to a cycle repeat. PACE is a model that promotes proactive action to interrupt that cycle, maximize functional status, and promote caregiver wellbeing.

Specifics for PACE include:

- An 11-member Interdisciplinary team involved and available to all enrolled patients:
 - Primary care provider
 - Registered nurse
 - Social worker
 - Physical therapist
 - Occupational therapist
 - Recreational (Activity) therapist
 - Home Health Aides and Certified Nursing assistants
 - Drivers (providing transportation)
 - Home care coordinator
 - Team Leader (program lead)
 - Registered Dietitian
- Provision of services to participants at no cost to the participant (if they are Medicaid enrolled) including all services normally covered by Medicare and/or Medicaid plus any services the care team thinks is necessary for the health and well-being of the patient.
- A PACE center where many participants spend time weekly (up to 5 days/ week) and where the Interdisciplinary PACE team interacts with each other and with enrolled participants.
- Capitated payments made to the PACE organization by Medicare and Medicaid. The Medicare payments are adjusted by the patient's risk score (CMS HCC-risk adjustment model). If the patient is not eligible for Medicaid, they can pay that monthly premium privately
- The PACE program accepts the responsibility to pay for all services not provided by the employed PACE team members such as hospitalizations, specialist visits, imaging, medicines, home health care, and transportation to necessary appointments.
- An interdisciplinary team (more integrated than a multidisciplinary team) that develops individual plans of care that are continually updated to the participants' needs and desired goals of care.
- Compared to similar populations, studies have shown an increased life expectancy for those enrolled in PACE, fewer hospitalizations, a lower percent of re-admissions, less Medicaid spending by the state, high satisfaction of enrolled participants and their caregivers with a 97% willingness to recommend enrollment in PACE to others.

Requirements to elect one's PACE benefit from Medicare are to be age 55 or older, live in a PACE catchment area, agree to receive your care from the PACE team, and be able to live

safely in the community with services. Massachusetts is one of 31 states that supports enrollment into PACE. We have 8 PACE programs covering much of Massachusetts including Summit ElderCare which currently provides services through 6 PACE centers in Worcester, Hampshire, Hamden, and Middlesex counties.

So, if your patient has functional impairments- either physical, behavioral, or cognitive- or if they seem to be struggling to manage their multiple medical and social needs, please consider referring them for evaluation for PACE. The PACE program provides no obligation assessments and will be able to advise if they are an appropriate care model. Visit the Massachusetts PACE website at www.masspace.net.

Innovation can be new, or it can be an older program that has been undersubscribed and underappreciated. PACE- The Program of All-Inclusive Care for the Elderly is a successful model of care providing an alternative to nursing home care by helping older adults better manage their medical, social, and long-term care needs including addressing their social determinants of health.

Dr. Wilner can be reached at dwilner@cpstn.com

David Wilner, MD, FACP, AGSF, is a Professor of Medicine at UMass Medical School, a senior medical consultant for Capstone Performance Systems and CareVenton Consulting, and was previously the medical director of Central Massachusetts' PACE program, Summit ElderCare.

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Trauma-Informed Care: A New Perspective in Providing Human Services



Sheilah H. Dooley, RN, BSN, MS

Recognizing the prevalence of trauma in the lives of those it serves, Pernet Family Health Service, Inc. is joining the growing number of human services providers nationwide taking steps to employ Trauma-Informed-Care practices into its service delivery. Pernet Family

Health Service is a nonprofit human service agency located in Worcester's Green Island neighborhood. Founded in 1968 by an order of religious sisters, The Little Sisters of the Assumption, whose mission was to provide health care and support to the disadvantaged families and to revitalize the spirit of those degraded by poverty, Pernet has remained steadfast in that mission, all the while seeking to advance its practices and embrace innovation, and to be responsive and impactful in the delivery of care.

The Sisters chose the intersection of Kelley Square, Green Island, and Vernon Hill for its site because sixty years ago, it was home to the greatest poverty in Worcester. This particular census tract is still predominantly populated by families living at or below the poverty line. Resources are scant. There are no grocery stores or healthcare facilities. The only human service agency is Pernet.

Pernet provides a wide variety of services addressing the needs of all ages, from at-risk expectant mothers and newborns, to early childhood, school-aged and the elderly. Home-based Clinical Services include Maternal and Infant Health Nursing; Early Intervention; Parent Education and Support; and Homemaker Services. Site-based Community Services include an Emergency Pantry of food, infant formula and diapers; Youth Services – homework assistance, recreation, and a jobs program for neighborhood children, youth jobs; Information and Referral to other community resources; Holiday Assistance; Family Outings; and Summer Activities. Pernet is a robust resource in a neighborhood that has precious few resources.

The people served by Pernet represent a population that is largely invisible. They are poor or struggling. Many lack a formal education. Some have criminal histories, struggle with addiction and mental health issues, are victims of abuse, experience language barriers and have immigration issues. Most have experienced some sort of trauma. And they are not alone.

The CDC reports that one in four children experiences some sort of maltreatment (physical, sexual, or emotional abuse). One

in four women has experienced domestic violence. In addition, one in five women and one in 71 men have experienced rape at some point in their lives — 12% of these women and 30% of these men were younger than 10 years old when they were raped. Thanks to a three-year grant from the Sills Family Foundation, Pernet will be creating an agency-wide training and reinforcement program, to introduce and implement the practice of Trauma-Informed Care.

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines a trauma-informed approach to services as one that includes the following principles:

***Safety** – physical and psychological*

***Trustworthiness & Transparency** – fostered over time by building and maintaining trust between staff and clients*

***Collaboration & Mutuality** – partnering and relationship building between clients and all members of the agency that respects and shares power and mutual decision making*

***Peer Support & Mutual Self-Help** – defined by SAMHSA as “valuing lived expertise; it should be available and nurtured by the provider or agency”*

***Cultural, Historical & Gender Issues** – a respect for differences, intentional avoidance of bias or stereotyping, appreciation of the value of cultural norms and traditions, and attention to traumatic histories*



SAMHSA
Substance Abuse and Mental Health
Services Administration

Pernet is committed to incorporating these principles of Trauma-Informed care to its service delivery model. Clients will experience this commitment in the ways that staff members ask permission, offer control, share information and provide support. All staff will participate in this training, because evidence shows that every facet of an at-risk individual's interaction with a provider such as Pernet can be impactful.

This focus on Trauma-Informed Care is a natural extension of Pernet's values: Belief in the dignity and worth of each individual; empowerment so that families have the tools to reach their full potential; dedication and commitment to supporting families in attaining their goals; recognition of every family's strengths and positive attributes; empathy for families facing challenges; teamwork; mutuality in relationships, we both give and receive; and respect for diversity and the richness of our differences. As an agency that endeavors to be forward-thinking and innovative in providing care to an at-risk population, the implementation of this program is a priority for Pernet.

The National Child Traumatic Stress Network reinforces this prioritization when it says, "Failure to prevent or adequately address the physical and psychosocial effects of childhood trauma, social determinants of health, and adversity carries a great cost to children, families and society. The centers for Disease Control and Prevention recently reported that the total lifetime estimated cost associated with just one year of confirmed cases of child maltreatment alone is approximately \$124 billion. Early identification, intervention, and support in key child-serving settings can help children recover and thrive following exposure to traumatic events."

Implementation of Trauma-Informed Care practices into every facet of the operation will have a significant and positive impact on the nearly 10,000 people Pernet serves each year. It will be a major step in bringing stability to families that have experienced hardship and trauma, and will ultimately strengthen the community.

Sheilah H. Dooley, RN, BSN, MS, is the Executive Director of Pernet Family Health Service, Inc., Worcester, MA; a graduate of Boston College School of Nursing; Affiliate Faculty in the Graduate School of Nursing at the University of Massachusetts, Worcester; and Clerk of the Board of Directors of the United Way of Central MA.

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"Where the Rubber Meets the Road": A Clinic on Wheels

Michelle A. Muller, MSN, FNP-BC

In August 2019, the UMass Memorial Ronald McDonald Care Mobile entered its 20th year of service. The Care Mobile program is based on a model of providing innovative, community-based medical services and preventive dental care onsite in neighborhood and school settings as a means of improving access to care, and a connection to on-going care. It is designed to serve the vulnerable, socio-economically disadvantaged, uninsured and undocumented children and their families living in Worcester County. The Care Mobile services 22 Worcester public and charter schools and 10 neighborhood sites across the city. Those sites include neighborhood and community centers, churches and public housing complexes. Some of the community center sites offer food pantries, housing services and other social supports in coordination with the services provided by the Care Mobile.

In spite of the numerous programs designed to serve the diverse patient populations found in Massachusetts, economically-disadvantaged children and their families have continuously fallen through the cracks when it comes to accessible medical and dental care. The Care Mobile program was conceived as a first-in-the nation prototype to address this problem in 2000 through a partnership with Ronald McDonald House Charities® and UMass Memorial Medical Center. Today, there are 50 Care Mobiles operating throughout the world. Since the beginning, the Care Mobile has been one of the flagship programs of UMass Memorial's efforts to reduce health care disparities within the community. By addressing the needs of uninsured/underinsured populations, the Care Mobile is helping to improve the health of individuals and our community while preventing unnecessary use of the Emergency Department (ED).

The Care Mobile is staffed by four caregivers: a community outreach liaison, a clinic coordinator, a dental hygienist/coordinator and a nurse practitioner/manager. The dental hygienist and nurse practitioner are overseen by a dental director and a medical director, respectively. The clinic and dental coordinators are licensed class B drivers, also called commercial driver's license (CDL), which is required to drive the Care Mobile.

The Care Mobile is a 40-ft long by 13.2-ft high vehicle that has been outfitted as a health clinic with many unique features. Patients are greeted in a reception area by the community outreach liaison and clinic coordinator; both are also trained

as licensed phlebotomists and certified Spanish interpreters. They register patients, manage patient flow, and refer patients to medical insurance counselors and new primary care providers. Once patients have been registered, they are directed to either of the two clinical areas. The medical exam room contains a patient exam table, a vitals machine, a manual blood pressure cuff, an otoscope/ophthalmoscope set and a sink. The dental hygienist performs cleanings and screenings in the dental room, which is equipped with a specialized dental chair, a portable dental cart and a sink. The reception area is also outfitted with a point of care testing laboratory (POCT) area, which consists of five POCT testing machines/kits, including urinalysis, hemoglobin A1c, rapid strep and blood glucose. The results of those tests are available within ten minutes and therefore are especially useful for management of the transient patient population often seen on the Care Mobile, allowing the patient and practitioner to formulate a medical plan. The vehicle is also equipped with computers and an internet connection, to facilitate patient registration, access medical records and document patient information into the EPIC electronic medical record system. In addition, the staff is aware of the community's social determinants needs and can recognize when a patient may need information and resources about other types of community services and help that patient obtain those needs.

The Care Mobile services include, physical exams for children, adolescents and adults, semi-urgent visits, lab testing, care for chronic illnesses, immunizations, dental cleanings and screenings, fluoride treatments, and both health and dental education. The Care Mobile collaborates with two local community health centers, to which patients are referred to after their initial dental cleaning on the Care Mobile. Our school based dental services include dental screenings, application of fluoride and dental sealants and referrals for restorative dental work, if needed. Staff members also participate in neighborhood events, ethnic festivals and community-based programs as outreach to medically underserved populations.

Each year, the UMass Memorial Care Mobile provides approximately 150 neighborhood stops and 60 dental service days in schools. Between 2000-2018, the program completed a total of 95,888 patient visits, 195,543 procedures and 77,346 dental sealants were applied. In 2018 alone, the program conducted 3,388 patient visits and completed 12,973 procedures. Other activities during the year included health screenings and educational sessions at special events, including events at the YMCA of Central Massachusetts, Assabet Valley Regional

Technical High School (Marlborough) and the Nueva Vida Church. The Care Mobile staff also hold flu clinics at community sites serving vulnerable populations such as the Worcester Adult Learning Center, Abby's House and the Ascentria Care Alliance. The goal of Care Mobile is to improve access to health and dental care and as such, many patients are referred to UMass Memorial health insurance counselors and local primary care providers. Given that Worcester has a large ethnically-diverse population, we will continue to work towards reducing health disparities. Our staff are honored to be a part of the community and strive for a future when every child and their families in the community will have easy access to ongoing medical and dental care in Worcester County.

For scheduling information or to make an appointment, please visit our web site at: <https://www.umassmemorialhealthcare.org/umass-memorial-medical-center/locations/ronald-mcdonald-care-mobile>.

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Care Mobile staff, from left to right:

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Stacy Hampson, RDH and Dental Program Coordinator
Rafael Gonzalez, Care Mobile Coordinator
Michelle Muller, FNP and Care Mobile Manager
Nardy Vega, Community Outreach Liaison

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The Role of Nursing in the Digital Health Strategy



**Teresa Rincon RN, PhD, CCRN-K,
FCCM**

In the 1970s the digital age began with the introduction of the computer followed by the introduction of the World Wide Web in 1989.^{1,2} In 2000, the Institute of Medicine recommended the development and testing of new technologies to improve access to safe, timely, effective, efficient, equitable and patient-centered care.³ Nurses and nurse practitioners (NPs) have had a pivotal role in executing a successful digital health strategy that leverage technology to provide the right care to the right patient in the safest and most timely manner.

Nurses and NPs have used telecommunication technologies to support patient care since the 1970's when the telephone was used to connect them with physicians in patient homes and pediatric clinics used bidirectional (two-way) cable TV to support a video enhanced face-to-face consultation.⁴⁻⁶ Nurses and NPs working in or with telehealth intensive care units (Tele-ICUs) have provided services to over 3 million patients across the United States since the early 2000s.⁷ Tele-ICU has been described as the delivery of services by expert critical care clinicians using telecommunication tools and other clinical decision alert and health information systems.⁸

Tele-ICU teams provide services in four major ways: 1) surveillance aimed at discovering which patients in a population are deteriorating and require an intervention, 2) expert advice and guidance, 3), dissemination and translation of evidence-based practice and 4) data collection analyses.^{9,10} Nurses and NPs can be and are used within these teams to achieve these four important services. In a recent publication, seven large health systems described how NPs and physician assistants (PAs) working in Tele-ICUs manage and coordinate the care of new and existing patients, communicate with the bedside care teams to evaluate patients and determine the appropriate plan of care, write orders, speak with families, ensure best practices are instituted, and even provide oversight and guidance during patient procedures.¹¹ In most Tele-ICUs, nurses are responsible for conducting surveillance activities, mentoring fellow nurses, responding to clinical alerts, leading best practice rounding, and collecting important data elements for quality reporting.¹²

UMass Memorial Medical Center (UMMMC) implemented a Tele-ICU program in 2006. Outcomes associated with the implementation of the UMMMC TeleICU have been previously reported.^{13,14} The logistic center approach (oversite of best practices and ICU bed utilization) used by the UMMMC TeleICU has been described in the literature as an effective, economical, and safe approach to resource utilization, triage, and improved adherence to best practice.¹⁵

The NPs, PAs and intensivists who staff the TeleICU also practice at the bedside in the Medical Center ICUs. The primary responsibilities of the NP/PA in the TeleICU includes continuous patient monitoring, admission triage, clinical consultation, e-prescribing and ensuring adherence to best practice protocols. Assessments, diagnoses, and treatment plans are discussed with the bedside teams and documented in the patient's record. They partner with the Transfer and Access Center (TrAC) to improve efficiencies and timeliness of patient flow in and out of the ICU. The TrAC team is staffed by experienced nurses who provide remote assessment and triage of patients needing therapeutic interventions by UMMC's highly trained and skilled providers of specialty services (trauma, cardiac, neurology, toxicology, urology, etc.).

VNA of Care New England and UMass Memorial's Health Alliance Home Health offer remote patient monitoring (RPM) services for patients with chronic conditions.^{16,17} RPM technology allows patients with certain chronic conditions to remain at home. Patients can communicate daily weights, blood pressure, pulse, oxygenation and other important information daily with a highly trained and skilled nurse who can assess and intervene as needed.

A recent systematic review of 16 high quality studies on RPM (out of 27 total) was encouraging with some improvement, although not statistically significant, in outcomes for patients with obstructive pulmonary disease, hypertension, Parkinson's disease and low back pain.¹⁸ Underpowered studies likely contributed to the lack of statistical significant changes. A meta-analysis using data from eight studies did not show any statistically significant difference in six different outcomes (BMI, weight, waist circumference, body fat percentage, and systolic and diastolic blood pressure) between those who used RPM and the controls.¹⁸ Additional research is needed on outcomes that matter to patients such as health related quality of life, symptom severity, satisfaction with care, resource utilization, hospitalizations, readmissions, and survival.¹⁸ The Centers for Medicare & Medicaid Services do not consider RPM a telehealth service and thus, there are no geographical restrictions. CPT codes: 99453, 99454 and 99457 can be used for RPM.¹⁹

Digital health innovations will continue to shape healthcare delivery. Nurses and NPs working within their scope of practice can ensure access to safe, timely and effective, efficient, equitable and patient-centered care using digital solutions.

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Enhancing Access to Care: Tele-Psychiatry



Cassandra Godzik, MSN, RN, PMHNP-BC

The technological advances made in health care during the past 50 years are phenomenal. One may think that telemedicine is primarily for rural areas where there may be fewer health care providers, but it is now also being used in busy emergency rooms as well as outpatient offices. For example, in many emergency rooms psychiatric health professionals are using mobile tablet carts to interact with patients via a screen on a tablet. This allows for real-time interaction between the patient and the provider and allows the provider to serve patients at more than one location. This facilitates patient care by allowing the psychiatric clinician to manage multiple psychiatric patients in two different psychiatric emergency departments providing access to more patients than possible if physically present in only one location.

A national shortage of psychiatric clinicians (Delaney et al., 2016; Harris, 2018) has propelled tele-psychiatry. Tele-psychiatry is the use of technology, often videoconferencing, through a computer or Smartphone device to connect patients and providers so that mental health care can be delivered via live, interactive communication. Patients can see their psychiatric clinician, and providers can see their patients while speaking directly with them.

There are benefits of tele-psychiatry to the patient and the providers. Patients experience reduced cost associated with transportation due to reduced travel time (Cowan, Alastair, Gentry & Hilty, 2019). Improved access may reduce delays in care and the need for emergency department visits. Patients can see their psychiatric clinician from the comfort of their own homes and have less missed time from work and family responsibilities (psychiatry.org/patients-families/what-is-telepsychiatry). Studies have revealed significant satisfaction with the use of these platforms from the patient perspective including both geriatric and veteran populations (Haghnia, Samad-Soltani, Yousefi, Sadr & Rezaei-Hachesu, 2019; Hantke et al., 2019). Therapy has had greater adherence and completion of sessions compared to traditional in-person psychotherapy sessions (Haghnia, Samad-Soltani, Yousefi, Sadr & Rezaei-Hachesu, 2019). Interestingly, psychiatric providers also reported benefits with findings indicating it may help reduce physician burnout (Reliford & Adebanjo, 2019).

An example of a common problem that can be managed via tele-psychiatry is insomnia. Risk of falls or maintaining adequate amounts of sleep, insomnia (Shamim, Warriach, Tariq, Rana & Malik, 2019), causes distress across patient populations, including those with co-morbid psychiatric and medical conditions (Bjorvatn, Meland, Flo & Mildestvedt, 2017). The Centers for Disease Control and Prevention (CDC) has identified insomnia as an epidemic and Bjorvatn, Meland, Flo and Mildestvedt (2017) reported that almost 50% of people seen in the primary care office experienced some level of insomnia symptoms. The problems associated with lack of sleep can impact daily functioning by decreasing concentration and increasing fatigue. In older adults, this can lead to increased risk of falls from lack of sleep and/or from medications used to manage insomnia symptoms (Lee et al., 2018).

In the field of psychology, use of cognitive behavioral therapy for insomnia (CBT-I) is the gold standard for treatment (Arem et al., 2019). The CBT-I program involves individual or group therapy in-person with a trained psychotherapist. There are, however, very few trained sleep psychotherapists across the country (Arem et al., 2019). The growth and acceptance of tele-psychiatry has increased the ability to disseminate CBT-I programs to patients across the country where patients might not have access to a trained clinician. The patient can access the program from their own homes via their computer or smart phone. While there can be a live person component to the program, i.e., patient and clinician interact synchronously with each other online or over the phone, many of these programs involve asynchronous interaction with the learning materials. Patient can access and use these materials when it is convenient for them. Programs like Sleep Healthy Using the Internet (SHUTi) and CBT-I Coach are available to patients via enrollment within a research study or directly through self-registration. The results of these tele-health programs have been positive, particularly with improvement of the subjective measures of sleep (Reilly et al., 2019; Moloney, Martinez, Badour & Moga, 2019). Further research is needed to assess change in objective measures such as those that could be captured via EEG and actigraphy.

Today, patients may never see their therapist in-person in a traditional healthcare office setting. They might not need to as long as tele-psychiatry and the evidence-based research behind it continues to support its use in practice.

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Innovations in Medication Therapy Management – Discussion of Reimbursement Challenges and Future Strategies



Kristen Milenki, PharmD¹,
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Medication Therapy Management (MTM) is defined by the American Pharmacists Association as a distinct service or group of services that optimize therapeutic outcomes for individual patients.¹ While MTM and patient counseling do have similarities, they differ in that MTM is done separate from dispensing of medications and involves a more collaborative environment between providers and patients.²

Medication Therapy Management was introduced with the Medicare Modernization Act of 2003 which involved a Medicare Part D requirement of providing MTM services to select beneficiaries in order to provide benefit to the patient in forms of education, improved adherence, adverse event detection and medication misuse prevention. In 2006, the Medicare Part D Prescription Drug Benefit required that MTM services be provided to high risk patients. High risk patients are defined as patients with multiple chronic illnesses and on multiple medications who are covered by Part D medications. In 2010, MTM expanded to non-Part D patients with the passing of the Affordable Care Act.²

Overall, the goals of MTM are patient centered; to improve the quality of life of patients by improving their drug use, optimizing their clinical outcomes while reducing risk of adverse events and health care costs.² There are many services that fall under MTM including assessing a patient's medical health and developing a drug treatment plan that will monitor and evaluate how a patient is responding to therapy. The tools used can include providing patient education to increase adherence and decrease preventable adverse events and collaborating with health care providers to improve the health outcomes of the patient.³

The professionals providing these MTM services are pharmacists that are MTM certified to provide these services in both inpatient and outpatient centers. While there are studies showing the benefits of MTM services for patients, the effect on pharmacists is not as often explored. This article will explore the clinical and economic outcomes of MTM services, different strategies that

can be used for MTM reimbursement, and innovative ideas that can be implemented to benefit both patients and pharmacists. The positive clinical and economic outcomes for patients using MTM services have been reported in many studies. One of these studies looked at patients with cardiovascular disease and reported a decrease in all cause medical and total expenditures among those who received MTM services.⁴ The study also showed that patients who received MTM demonstrated a clinical significance in the number of patients who achieved treatment goals and improved disease stages for hypertension and BMI. Another study focusing on the effect of MTM interventions among outpatients with chronic illnesses showed that MTM interventions reduced the frequency of medication related problems including non-adherence and reduced health care costs.⁵

Despite the evidence of positive health outcomes with patients who receive MTM there exist several challenges for pharmacists that have staggered its universal adoption. One of the challenges is lack of reimbursement for pharmacists and pharmacies.⁶ Resource-based relative value scale, a metric developed in response to the Social Security Act in order to align the payment rates and which is often used for MTM reimbursement, consistently resulted in lower reimbursement amounts than the time-based billing method (TBBM).⁷ Additionally, utilizing contingent valuation, Wang and Hong found that the payment pharmacists' are prepared to accept for a given MTM is higher than current Medicare compensation levels.⁸ However, there have been attempts to better align and incentivize pharmacist payments for performing MTM. The Pharmacy Society of Wisconsin created an integrated network of community (independent, chain, and health-system) pharmacies and payers. The pilot program compensated network pharmacies on quality-based requirements which included patient care and standardized service.⁹

Combining high-quality consistent MTM with professional reimbursement has the potential to revolutionize the community pharmacy practice model. Incorporating MTM services within an integrated health care system has the potential to improve clinical outcomes and reduce costs.¹⁰ Over a 10-year period pharmacist cost savings to a health system were \$86 per MTM encounter with a total cost of \$67, for an estimated return on investment (ROI) of \$1.29 per \$1. Similarly, the ROI based on TBBM ranged between 1:5 to 1:25.¹¹ An additional challenge regarding MTM enrollment is physician awareness. The University of Illinois Outpatient Care Center performed a qualitative study based on healthcare professional perception on pharmacist-led

MTM service and found that the lack of knowledge on the appropriate referral procedure was the prominent reason for reduced patient enrollment.¹² Furthermore, a similar survey done by The New York City Department of Health and Health Hygiene noted that key concerns of physicians regarding pharmacist-led MTM services were pharmacist competency, workload impact, and lack of effective collaboration between pharmacist and physicians.¹³ Many of these concerns are addressed through existing collaborative agreements. The use of collaborative practice agreements to deliver MTM services to patients with chronic conditions taking multiple medications resulted in better therapy optimization when both physicians and pharmacists worked collectively and had clearly defined roles.¹⁴

In short, MTM services have a proven record to benefit all members involved. The upfront cost of initiating and maintaining these programs is negligible when the high ROI is considered. Educating patients, providers, pharmacists, and payers on their respective contribution in the treatment paradigm is critical in order to ensure universal acceptance of this practice. Numerous pharmacies have found innovative ways to increase their MTM practice by collaborating with different medical entities. Several providers are partnering with community pharmacies to deliver MTM services and support for injectable biologics to reduce disease burden management. Furthermore, hospitals have begun partnering with MTM pharmacies in order to decrease the rates of readmission through pharmacist identified interventions.¹⁶ Moreover, to expand access to patients, pharmacies are using telepharmacy to perform MTM. This practice not only has potential to increase patient enrollment, but also decrease cost.¹⁷ Schwartz et al incorporated an MTM Plus approach which included medication risk mitigation factors, as well as, pharmacogenetics testing.¹⁸ This approach would not only allow pharmacists and physicians to identify medication related problems and drug-drug interactions, but also drug-gene interactions. Finally, to ensure the next generation of pharmacists are ready, willing, and able to provide MTM, pharmacy schools have incorporated MTM certification programs into the curriculum.¹⁹ Ultimately, it is the patient who benefits the most from these interventions. It is with this continued goal of ensuring patient effective treatment and safety that MTM services should become a mainstay of contemporary clinical practice.

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Building a Communication Tool for Non-Speaking ICU Patients



Miriam Goldberg, PhD

Over the last five or so years, I have had the opportunity to build my dream project - a communication system designed for individuals using a breathing tube (or breathing through a tracheostomy) in the Intensive Care Unit.

My path to this project began during my time as an undergraduate and master's student in the MIT Media Lab, I worked with colleagues in the Affective Computing Group to design a personalized emotion-discerning teaching tool for children and young adults with severe autism. My experience on the project was influenced by my frustration with the assessment tools available for this population: our method of assessing emotional state for the individuals we worked with relied on a subjective survey. For our non-speaking autistic subjects, answering the survey themselves was impossible, so caregivers answered the questionnaire on behalf of these individuals. I felt that there must be a better way to allow these individuals to communicate directly.

Through this project, I found that there was a deep-seated need for improved communication tools for people who cannot speak. These tools are generally called Augmentative and Assistive Communication (AAC). Certain subsets of these individuals are relatively well-served by existing AAC tools; for instance, many people are familiar with Stephen Hawking and the sophisticated system for communication that he used throughout his life. Similarly, the use of some types of communication tools (both low- and high-tech) by children with autism, in particular, has become generally well-known.

However, a wide variety of individuals are not served well by existing communication tools, including people with Parkinson's, cerebral palsy, muscular dystrophy, spinal cord injuries, and post-stroke sequelae. Most users do not experience a period where they are able to learn to use a sophisticated system. (This might be either because they are born with a motor impairment obstructing their use of a sophisticated system, as in cerebral palsy, or because their need for use of such a system is precipitated by a sudden event, as with spinal cord injuries.)

For individuals in either group, the need for a communication system that can be accessed with motor impairments is significant.

Additionally, there is a large group of potential users for such a system who may need it only temporarily: patients who are receiving respiratory assistance in an Intensive Care Unit (ICU). These individuals often report feeling extreme distress and unhappiness related to not being able to communicate. In fact, despite the many other challenges these patients face related to critical illness and resulting treatment, several studies have found that they rate inability to communicate as the most significant stressor of their ICU stay. Furthermore, rates of PTSD, anxiety, and depression are often quite elevated in these patients after their ICU stay - it may be that reducing the intensity of their most active stressor can combat these psychiatric sequelae.

As I discovered the need for this type of communication system, I also assembled an interdisciplinary advisor team (Robert H. Brown Jr., DPhil, MD, professor and former chair of neurology; J. Matthias Walz, MD, professor and chair of anesthesiology and perioperative medicine; and Leigh R. Hochberg, MD, PhD, professor at Brown University and a neurologist at Massachusetts General Hospital). Throughout this project, these advisors have supported me in the development, testing, and analysis of the approach I developed to assist ICU patients with their communication needs.

Ultimately, the system that I have developed is apparently quite simple, but incorporates a significant amount of feedback gathered over many years of testing and discussion with clinicians, patients, and family members.

Initial "needfinding" shadowing sessions in the ICU suggested a few basic design constraints. First, patients needed a device/system that would require less fine motor capacity than writing or typing, which are often frustrating for both the patient and their family/caregivers. Second, the approach used should be more sophisticated than a paper letterboard, which is the other default communication method in the ICU setting. Third, even for patients who might attempt to write, mouthing words is a frequent method for attempting communication; this fact suggests that patients may specifically desire to communicate orally, so a communication solution should encourage spoken questions/responses.

Finally, the nature of patients' positioning (usually with head at a 30 degree angle to the bed) and motor capacity (generally it is difficult for patients to keep their hands elevated for any significant length of time) suggested that having a visible screen and an "access method" available in two different places - in particular, on a bedside table and available for immediate reach,

respectively - would address the some of the physical constraints of the ICU setting (and of experiencing critical illness) of these patients. Other constraints also presented themselves: the communication approach should include a battery-powered system, large and highly visible text, and an oversized and bright screen.

Working within these constraints, and with ongoing feedback (first from speaking patients, and then from ICU patients with a tracheostomy and/or an endotracheal “breathing tube”), I developed a system I call MOCS, for Manually Operated Communication System. MOCS consists of a 12.9” iPad that is wirelessly connected (via Bluetooth) to a custom-designed object, the MOCS access device. This device is about the size of a tennis ball and can be moved in any direction, as well as squeezed. When it is moved in the compass directions (forward, back, left, and right, relative to the user), it reflects the movement of the current selection on the iPad screen - forward maps to “north”, left to “east”, etc. By moving among the onscreen options, which

are mapped to the points of a compass, and squeezing when the desired option is selected, the user is able to select from options such as “Pain”, “Physical Needs”, “Breathing Tube”, etc.

MOCS testing has begun with patients at both UMass Memorial Medical Center and the Massachusetts General Hospital (<https://clinicaltrials.gov/ct2/show/NCT03630003>). Analysis of the results is ongoing, but preliminary results are encouraging.

Miriam Goldberg is a PhD candidate in her eighth year of the MD/PhD program at the University of Massachusetts Medical School; she plans to pursue physiatry (Physical Medicine & Rehabilitation) after graduation. She is also a visiting researcher in the Brown University School of Engineering .

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Introduction: The 2019 Creative Writing Exposition

Robert Sorrenti, M.D.

Once again, Worcester Medicine has agreed to publish the blue-ribbon entries in the Creative Writing Exposition of the Massachusetts Medical Society (MMS) Arts, History, Humanism & Culture Member Interest Network (Arts MINS). The Arts MINS is a standing committee of the MMS, which provides a forum for members to explore, develop and participate in non-medical activities. These activities have ranged from bird-watching to bonsai-planting, from art exhibitions to astronomical viewing and include sponsorship of the Creative Writing Exposition.

Held about every other year, the Creative Writing Exposition invites members of the medical society to submit personal works of prose or poetry. The entries are evaluated by a panel, and those judged to be "blue ribbon" are printed in Worcester Medicine. This year, we had a number of entries, including works of fiction and non-fiction, as well as various forms of poetry. We appreciate the participation of all the authors in this exposition.

We know how busy doctors can be. This exposition highlights what some of our physicians do in their spare time. The entries being published in Worcester Medicine provide a glimpse into the personal lives of two physician authors. I hope you enjoy reading these pieces and join me in thanking the authors for sharing their thoughts with us.

In closing, let me invite MMS and MMS Alliance members to take part in some of the activities and events the Arts MIN sponsors and to join us on the executive council to promote new areas of interest. Robert Sorrenti, M.D., is the chairman of the Massachusetts Medical Society Arts, History, Humanism & Culture Member Interest Network (ARTS MIN).

The Visitor

Dr. Paul Berman

It was quiet and dark in the library with one lamp lit at the end of the table to read by. This was my place to escape the pressure and stress of the hospital and I had made it a nightly habit to come and sit quietly reviewing the day's work and catching up on the news both medially and socially. My phone was the only thing that attached me to the outside world, but I put it on vibrate so it would not break the silence of the room. Here I could be alone with my thoughts and love of books.

The Library was usually empty at this time of night, most of my colleagues taking the break time to nap before the next rush

of patients. But this evening was different, I became aware of another person in the room, a bearded old man sitting at the end of the table. He didn't seem to move. I thought he was reading without a light, sleeping or, god help me, dead!

But he looked familiar. Was he an old staff member? I am sure that I had seen him somewhere. How did he get in the library? I just could not place him. Was he a former professor of mine or a patient? He stared straight ahead at the stacks of books seemingly unaware of my presence. I watched him and finally decided to introduce myself. I walked over and said hello. He turned and looked at me smiling and called me by my name. How did he know who I was? Are you reading history he asked? I answered: "history of medicine." I told him this library contains not only up to date resources but voices of the past, like Hippocrates and Galen whose precepts about "mal air" guided the profession well into the late 19th century. I mentioned Pasteur who showed that those little "bugs" under the microscope could cause human disease. I was on a roll and noted that there was also Harvey's work on blood flow; Sydenham's description of diseases like gout, scarlet fever, measles and cholera. He emphasized "observation and experience" something we sometimes forget in this technical age. There was Auenbrugger who developed percussion, Laennec the stethoscope, Louis analysis, Austin Flint who grew up in a town near me and founded Buffalo Medical School and wrote a wonderful book on medicine and Osler who can forget Osler. It is so important to understand where we as physicians came from, how we got to this level of sophistication. Knowing our history is important, like knowing the history of our patient."

The man listened to my discourse and at the end simply said: "Osler hmmm wasn't that the man who stated: "the practice of medicine is an art based on science." I was surprised, that was one of Osler's famous aphorisms from a lecture he gave to students. Yes, I said, a great lesson as important today as when Osler stated it years ago. Especially now with our scans and robots we seem to be losing the sense of caring for the person. We are cracking the gene which promises great things, but the cost will be prohibitive, what I like to call "commercial eugenics". Only the rich will be able to afford that care. We seem to forget that our science contains lots of uncertainties which still require judgement and yes, experience. The art is as important as the science, maybe more so as we learn more and more about less and less. He laughed and said: "remember...." But was cut off when my phone suddenly lit up, "ICU-Stat". I am a critical care specialist. I wanted to stay and continue our conversation, but the hospital was calling. I turned to tell him I had to go and regretted not being able to continue our conversation, but he was no longer at the end of the table, he had disappeared. I heard no footsteps, no door closing, nothing. Had it been a dream? Had he really been there? Who was---the visitor.

Dr. Paul Berman is a Retired internist with an interest in medical history. "The Visitor" was inspired by the history of medicine, concern of the changes, since I left practice and need for doctors to read more and understand the art as well as the science. Important to recognize uncertainty as well as certainty. Staying human.

Creeping Charlie

Ronald W. Pies, MD

From our kitchen window,
I see you weeding
in the back yard,
hunched over a patch
of Creeping Charlie.

My reading tells me
how *Glechoma hederacea*
is hard to kill,
how it spreads
by seeding, rooting,
and stubborn stems.

To my ear,
“*Glechoma*”
brings to mind
the invasive
you’ve been battling
five years now,
root to stem—
though “*myeloma*”
has a softer sound.

You, love,
are more stubborn
than thuggish weeds
or mutated cells.
Five years now,
and you have stood
your ground.

Ronald W. Pies, MD is a psychiatrist on the faculty of Tufts University School of Medicine; a medical ethicist; and the author of several works of poetry and fiction, including the chapbook, The Myeloma Year; and the novella, The Shepherd of Lost Children. Dr. Pies writes of this poem: “I was inspired by seeing my wife, Nancy, working hard in the garden, trying to get rid of a stubborn, invasive weed. The image called to mind her own battle against multiple myeloma, another “invasive”, and her fierce determination to uproot it.”

As I See it: Two Women – One Mission

Nancy Whalen

“To provide a suite of services that offers physical, emotional and spiritual support and comfort to the family and friends of hospitalized patients in the greater Worcester area.”

The dream to open a hospitality house began over 36 years ago. I lived close to UMass Hospital and was also employed at the hospital as a financial counselor. I can still remember helping one family struggling to support their son. He was a Worcester college student that lost his leg in a motorcycle accident. His mother traveled daily from Springfield with her handicapped daughter. She was physically and emotionally exhausted and facing large medical bills. She was a strong advocate for her son and we formed a friendship. When her son was approved for his social security disability, she brought a bottle of champagne, and a gift for my baby. I was just doing my job, but I wished I could have done more to help. The seed was planted. Over the years working at the hospital I witnessed many families struggling to be with their hospitalized loved one. Many slept in chairs or waiting rooms, too far from home to travel back and forth and unable to afford hotels. Families lived moment by moment, not knowing if their loved one would recover, trying to support their loved one in the hospital and loved ones at home.

In 2007, my husband became disabled from cancer and in 2008, my son became disabled from a work injury. I was either working or visiting at the hospital. One perspective as a hospital employee was seeing the challenges faced daily by staff, as well as a caregiver to my hospitalized loved ones. I witnessed personally how invaluable family support is to the hospital and to loved ones. My husband was in and out of the hospital numerous times. On one hospitalization his face was swollen after surgery, the hospital staff didn’t realize it, but I saw it immediately. He was having an allergic reaction to his medication. Families are keenly more aware of any changes in physical and cognitive function than hospital staff.

We were lucky to live close to the hospital, but many patients live far from home. The need for family-centered lodging during long-term hospitalization is vital. Research has demonstrated that the presence and participation of family members and friends—as partners in care—provides cost savings, enhances the patient and family experience of care, improves management of chronic and acute illnesses, and prevents hospital readmissions.

From the beginning, I shared my dream with my friend and co-worker, Carol Lewis. We worked tirelessly for many years to reach our goal. Our dream became a reality. Healing Heart Hospitality House (www.healingheartshouse.org) opened its doors in January 2019. It was a long road to finally have a place that families facing a medical crisis could have a home-away-from-home. Healing Heart Hospitality House is a non-profit 501 (c)3 private community resource.

We are members of the Healthcare Hospitality Network (www.hhnetwork.org). They have nearly 200 hospitality house members across the country. If you find yourself in the need of a place to stay while a loved one is hospitalized far from home, a directory of hospitality houses is listed on their website, including Healing Heart Hospitality House.

<https://www.ipfcc.org/resources/visiting.pdf> Boudreaux, Francis, & Loyacono, 2002; Brumbaugh & Sodomka, 2009; Chow, 1999; Davidson, et al., 2007; Edgman-Levitan, 2003; Fumagalli, et al., 2006; Garrouste-Orgeas, 2008; Halm, 2005; Lewandowski, 1994; Sodomka, 2006; Titler, 1997).

Nancy Whalen, Co-Director Healing Heart Hospitality House
Retired from UMass Memorial Health Care

Worcester Medicine Looks Back: News from the Archives

We begin a column looking back at Worcester Medicine in the past to provide perspective to issues that are still with us.

B. Dale Magee, MD, WDMS Curator

Worcester Medical News; 1957, vol 24 (4), 4.

RISING HOSPITAL COSTS- I

Personnel Facts

For the past 10 years constantly mounting hospital costs have caused considerable concern on the part of physicians and the general public. Health is our most important commodity and serious illness can make irreparable inroads into family savings. It is vital to the community to understand the problems of a modern-day general hospital. The figures show how real this problem is.

The average cost per patient day for all short-term general hospitals in the United States during 1946 was \$9.19. By 1954, this cost had risen to \$21.76, an increase of 132%. During the same period the consumer price index, utilizing the 1947-49 base for 100, advanced only 37.6% for the nation, rising from 83.4 at the end of 1946 to 114.8 at the end of 1954. Even though the consumer price index has remained almost stable since 1951, rising less than half a point per year, the costs per patient day at general hospitals have increased by 7% per year during the same period. Unless there is a very significant decrease in the general economic situation, we must expect hospital costs to continue to increase at about 5% annually for many years. Only by the best efforts of hospital boards, administrators, medical staff and employees can costs be held to within that level of increase.

Factors Controlling Costs

The factors, controlling increased costs, are built into the nature of hospital operation. The chief cause is that hospitals are personal service institutions. Personal service means people instead of machines. The majority of hospital work requires the presence of individuals and utilization of judgment as well as hard labor. The opportunities for alternative use of machines when the cost of labor exceeds the cost of a machine are not too abundant in the hospital. The age of automation has not increased the productivity of the hospital worker. One method of solution was the substitution of less skilled personnel to perform service duties under the direction of professional employees in the hospital. This reflects on the financial credit of the institution but for the welfare of the patient, in many instances, hospital management has grasped at too many of these draws for their economic salvation. The major criticism heard from patients regarding hospital care is concerned with the lack of warmth and emphasis on efficiency rather than tender, loving care. It is time that the nursing profession realizes that the care of the patient is the primary reason in their vocation and not the financial reward which should be a secondary consideration.

Hospital Personnel Data

Data, from the 1954 American Hospital Association Guide, strongly illustrates the importance of personnel factor on hospital costs. Of the \$5.2 billion expended by all hospitals in 1954, 64% was for payroll. For the nine-year period, 1946 through 1954, total cost of general hospital's increased \$12.37 per patient day. Of this increase \$8.23 was in payroll alone. While the total cost per patient day were thus rising by a factor of 132%, the payroll costs per patient day rising at the rate of 165%.

Economists agree that the total United States productivity has increased per man hour at an annual rate of over 2% for the past 75 years. Since 1946 this increase has averaged 2.9% per year for the nation as a whole. In November 1955, Fortune magazine predicts an average annual increase of 3%, compounded, for the next 25 years. This increased production has been the cushion by which much of the increased wages of labor have been absorbed. Because of this phenomenon of increasing productivity per man hour in industry, made possible largely through constant improvement in the machines and supplies provided the worker, industry has been able to grant sharp wage increases without equal increases in costs of productivity.

The hospital worker provides little opportunity for such productivity gains. Nonetheless, hospital salaries are affected by general salary levels. Under such circumstances every round of salary increases constitutes a direct increase in hospital costs. In the future as general labor continues to receive increased wages from higher productivity, hospitals will be compelled to give equal increases in salary without comparable benefits. It is inescapable that the cost of hospital care will follow very closely the constantly increased real wage level of industry.

Hospital Recruitment

Another major headache constantly testing the ingenuity of the hospital administrator is the problem of personnel recruitment and its effects on hospital costs. From 1946 to 1954 the number of employees has increased by over 50% while during the same time interval the total number of employed civilians for the entire nation rose to slightly over 10%. This rapid recruitment was accomplished in part by rapidly increasing rate of pay. This is reflected in the increase in wages during this period to all civilian employees in this country at 59.1% while hospital employees gained a 101.5% increase. These increases were required to bring the traditionally lower hospital salaries into competitive alignment with wages offered by all other employers.

Hospitals are community agencies and are committed to meeting community needs for hospital care. This means hospitals must be staffed to meet the peak requirements anticipated at any given time. These requirements fluctuate wildly and are in part predictable and in part non-predictable. Hospital personnel must have regular and full employment. The readiness to serve requirements in order to meet the unpredictable fluctuations will seriously handicap any substantial staffing adjustments. The costs of standby services make up an extremely large portion of the hospitals operating costs and are largely beyond the control of the hospital administration.

Hospitals are an important and intimate part of the average American's life. They perform an essential community service and the hospital administration must except responsibility for producing that service in the most efficient manner possible. The members of the community have the responsibility of understanding the nature of hospital costs and specialized services provided. Even with the best efforts on the part of all concerned, hospital care is inevitably going to become increasingly expensive.

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“Consumerism” has for some time been touted as an alternative to health care reform efforts such as Obamacare and Medicare For All. The argument goes that, if only health care consumers had accurate quality and price information, they could make their own decisions and thereby drive down the cost of care in a

real market setting. Prior efforts to provide such information have had a mixed record, and it is not clear to what extent individual patients are able and willing to comparison shop regarding health care goods and services. Now the federal government is proposing two rules that would require hospitals and health insurance carriers to provide such information to their patients and subscribers. At least for the near term, it appears that any benefit from these new rules may accrue largely to others, and not directly to patients, but the ultimate impact of the new rules might be enormous.

The two rules were published on November 27, 2019 in the Federal Register. The first rule concerns hospitals and is in its final form with an effective date of January 1, 2021. The second rule concerns health insurers and is currently in proposed form. Under the rules, hospitals are required to post online a list of payer-specific negotiated charges as well as chargemaster charges and payer-anonymous minimum and maximum negotiated charges, as well as discounted cash prices payable by self-pay consumers. In addition, hospitals must post online a second list of the same sort of charges for up to 300 “shoppable services” using a plain-language description of the service and adding information about the location where the service is provided. The two lists would be updated annually.

The proposed health insurer rule would require a health insurance issuer or group health plan to provide an estimate of the beneficiary’s cost-sharing liability for a covered service, in response to a specific request from the beneficiary and through provision of a written description or an internet-based self-service tool. In addition, beneficiaries would be informed about the in-network negotiated amount as well as the out-of-network allowed amount for the item or service and information as to whether that item or service is subject to a prerequisite such as prior approval. If the beneficiary requests information about an item or service that is part of a bundled payment arrangement, the payer must provide a list of the bundled items and services included in the cost-sharing information. In addition, the payer would be required to post in-network negotiated rates on a publicly-accessible website that is updated monthly.

If you were to design a system to provide patients with actionable intelligence to enable them to purchase the highest quality health care for the lowest cost, you might want to ensure such a system provides them with comparative quality and cost information for a variety of providers. The two federal rules do not do that. The final hospital rule does provide patients with insurer-specific allowed charge information provided by the reporting hospital whose list the patient consults, and places that information within the context of the maximum and minimum allowed charges paid to that hospital for the item or service in question. The Department of Health and Human Services commentary to this rule repeatedly says that by doing so, the rule is intended to provide patients with a “full line of sight into their healthcare pricing.” Significantly, however, this line of sight will not include a view of fee for service Medicare or Medicaid charges, since those are not negotiated by the provider. Moreover, in order to compare different hospitals’ negotiated charges, the patient would have to consult multiple hospitals’ lists. A comparison of different hospitals’ quality metrics for a given item or service would require the patient to consult other resources, to the extent these are available.

“...the rule is intended to provide patients with a ‘full line of sight into their healthcare pricing.’”

If you were to design a system that would give patients specific information about their out of pocket costs for a given item or service, you would provide the type of information found on evidence of benefit documents, currently delivered only after the date of service. Although the final hospital rule does not provide that information, the proposed health insurer rule does, through the provision of information about how the patient stands with respect to his/her deductible or any out of pocket limits, as well as the required co-pays or co-insurance and prerequisites such as prior approvals or step-therapy requirements. The health insurer rule would require disclosure of the negotiated rate paid by the insurer for in-network as well as out-of-network providers. However, if the patient’s cost-sharing liability (e.g., deductible, co-pay or co-insurance) is not affected by the negotiated rate, the negotiated rate need not be disclosed. This could happen if a deductible does not apply or if the co-pay or co-insurance amount is a flat dollar figure.

If you were to design a system to enable patients to determine where best to receive a service, you would provide patients with

comparative cost and quality information for a given service that might be provided in different types of settings – for example, a surgery performed in a hospital or in an ambulatory surgery center. You would also provide price information for services provided by non-hospital providers that are ancillary to the services provided by the hospital, such as physicians who are not hospital employees and independent physician groups, which bill and collect separately from the hospital. Neither of the federal rules require the provision of such information, since the statutory authority for the hospital rule is limited to hospitals and cannot require non-hospital providers or sites of care to publish price information.

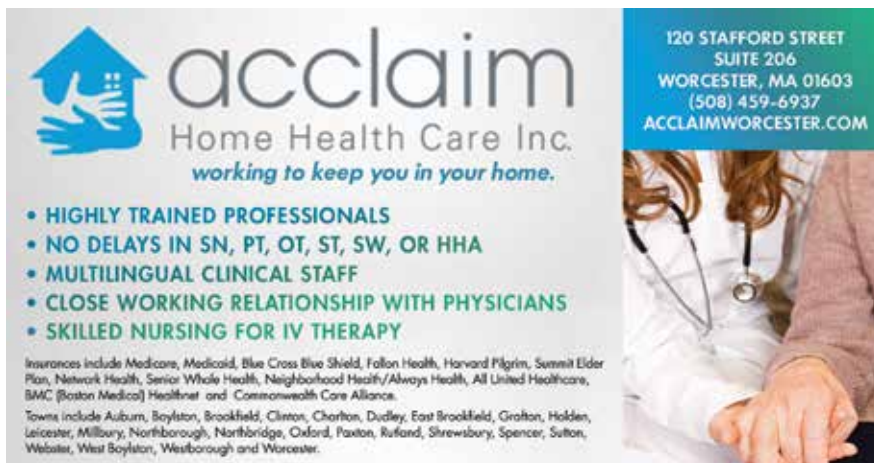
The shortcomings in the hospital rule were highlighted by litigation filed by the American Hospital Association and other parties on December 3, 2019. Among other arguments, the plaintiffs make a First Amendment claim: that prices negotiated between hospitals and insurers have always been considered proprietary trade secret information the disclosure of which can be justified only if the disclosure advances a substantial governmental interest and the disclosure is narrowly tailored for that purpose. DHHS notes in response to the trade secrets argument that not only are the negotiated rates available to patients through EOBs, but “price transparency vendors” and “private entities that use crowdsourcing efforts” can gain access to the same information, as well as states that publish negotiated rate information. As to whether the rule is “narrowly tailored,” the government seemingly concedes the point that the hospital rule provides a rather blunt instrument; at one point, DHHS says that disclosure of “standard charges” is “merely a necessary first step” in empowering health care consumers with price information.

Plaintiffs in the AHA case also argue that such disclosures would hamper rather than promote price competition since price negotiations would no longer occur in private. In the hospital rule, DHHS seems skeptical of this argument; it quotes a study as follows: “concealing negotiated price information serves little purpose other than protecting dominant providers’ ability to charge above-market prices and insurers’ ability to avoid paying other providers those same elevated rates.” This language echoes the findings of the Massachusetts Health Policy Commission in its 2016 Cost Trends Report: “the HPC found that hospitals with higher market shares and those with certain large system affiliations tend to have higher inpatient prices that are not tied to increased quality The HPC also found that while some variation in pricing may support activities that are beneficial to the Commonwealth (e.g., provision of specialized services or stand-by capacity), much of the variation in inpatient hospital prices is likely unwarranted and reflects the leverage of certain providers to negotiate higher prices with

commercial insurers.” It is in the government’s consideration of the effects of the rule on competition that the focus on the rule’s benefits shifts from patients to others.

The anticipated benefits stemming from the disclosure of hospital negotiated charges accrue less to the “patient” than to the “general public.” This is seen in the government’s apparent expectation that the disclosed negotiated rate information will spur the development of “consumer-friendly price transparency tools.” The importance to the government of the development of such tools is reflected in the fact that the hospital rule deems hospitals that offer “online price estimator tools that provide real-time individualized out-of-pocket cost estimates” to have met the regulatory requirement to publish charges for “shoppable services.” DHHS notes in the preamble to the hospital rule: “While we cannot discount the possibility that some consumers may find required hospital data disclosures confusing, we believe that the vast majority will find the increased availability of data, especially as it may be reformatted in consumer-friendly price transparency tools, overwhelmingly beneficial.” Here the government seems to contemplate the advent of healthcare-related websites along the lines of those that today exist in the travel, dining and hotel industries.

Should either or both of these rules come into effect as written, the impact on the health care landscape may be as dramatic as the advent of the Affordable Care Act. Initially it would appear those impacts will accrue to the benefit of health insurers and the creators of price comparison tools. Disclosure of privately-negotiated hospital prices in the concentrated eastern Massachusetts market might have dramatic effects beneficial to smaller and community-based hospitals and other lower-costs sites of care. More broadly, making negotiated prices public may reduce price disparities among providers and require them to compete on other terms, such as quality and convenience. Ultimately, diffusion of out-of-pocket cost information to the general public prior to service delivery through truly effective cost estimator tools concerning a broad range of items and services might finally effectively change individual patients’ behavior and turn them into true health care “consumers.”



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Russo Italian Restaurant: Where Fine Dining and Family Come Together

Bernie Whitmore

With some of the most handsome dining spaces in town, 65 Water Street has been the site of several different restaurants in the past couple decades. Half a flight down from street level, the rooms feel ancient with heavy wooden beams, rough stonework and plenty of brick. Russo Italian Restaurant has integrated so well and so quickly into this space that on my first visit they seemed like a perfect match.

And, based on the 'market' display windows showcasing aging meats and cheeses and all their homemade pasta shapes, they also impress as authentically Italian. Before we could be seated, I felt my expectations soar.

Then Sue, our server, greeted us and recited a tour through menu highlights. We were encouraged by her enthusiasm, the depth of the menu and her informed descriptions. All this food-talk was increasing my appetite; as if sensing that, she brought a basket of moist focaccia bread and bowl of herbed dipping oil.

In selecting an appetizer, I noticed that at least half the offerings were not the standard fare you see at most restaurants. In addition to offerings such as Fried Calamari, they also have items such as Grilled Octopus and Stuffed Cherry Peppers.

We decided to share another unusual offering: Fried Smelts. Ok, these fish don't have the most appealing of names – I had to journey to the Baltics to 'discover' them – but they're well-worth investigating. They look like overgrown sardines and are served whole; Russo's gives them a thin coating of crumbly breading and deep-fries them to light golden brown.

The generous portion, at least a dozen, came stacked aside arugula leaves and a dish of warm lemon caper brown butter. The tart lemon and almost olivey flavor of the capers were a hugely successful match to the fragile flavor of the smelts. This was a totally unexpected delight and served to increase my entrée expectations.

Eggplant Parm Pie, one of the entrées that Sue had mentioned, sounded too good to pass up. They layer soft eggplant slices with marinara and mozzarella cheese and encase them in a sheet of pasta dough. This is covered with more marinara and a showering of grated parmesan cheese and baked. Baked till the outer cheesy edge is a luscious melty shell and the eggplant has become rich and tomatoey. Then they cut a wedge, about the dimensions of a huge chunk of chocolate cake and serve it over more of the marinara.

First tasting: Russo's marinara! Tangy-rich with a depth of tomato and herb flavors that can only be developed with time and care. But not over-processed; it still has some zesty acid character. And the eggplant: silky-soft and integrated into the rich tomatoey goodness. All these flavors baked into the jacket of soft pasta clad with that fusion of parmesan and marinara forming a chewy outer layer. I savored every bite.

This called for a hearty red wine, a glass of Duca Minimo Montepulciano d'Abruzzo. Tasting of ripe summer berries, this ruby-red wine retained a freshness that wasn't so bold as to bully the flavor of Russo's tasty marinara.

From the other end of Italian cuisine's color-flavor spectrum, my companion went with a standard: Carbonara. Pancetta is typically used to provide a touch of smoky salt structure to this dish. But Russo's chef uses guanciale, a close flavor match that comes from the jowl of the pig. If you're not paying close attention you wouldn't discern a difference.

The main event of the dish was the eggs and cream with a generous dash of fresh pepper. All simmered together with Parmesiano Reggiano cheese and served over a plate of fresh spaghetti. The forkful I snagged was eggy and mild in flavor. Delicious. My friend would have appreciated the addition of more grated cheese. Can there ever be too much cheese?

Having cleared our dishes, Sue returned with a dessert display. Their chocolate cake was tempting, but we chose Tiramisu. Russo's pastry chef uses thin layers of sponge cake soaked with coffee syrup and the traditional creamy mascarpone filling. Its flavor reminded me of the spice cakes my mother used to make.

For those of us who love Italian food, Russo's is a welcome addition to the Worcester dining scene. They push the cuisine with creative gusto and innovation. In fact, on Sundays they push their regular menu aside and serve a traditional Italian family dinner. When was the last time you experienced that?



Russo Italian Restaurant
65 Water Street, Worcester
Phone: (774) 243-1377
www.russoworcester.com

Worcester District Medical Society

Calendar of Events

2019

2020

September 13 Friday 7:30 a.m. Beechwood Hotel	28TH ANNUAL WOMEN IN MEDICINE BREAKFAST Speaker: Marcia Lagerwey, senior curator of Education, Worcester Art Museum Title: A Medical Journey: Pregnancy and Birth in the Art of Otto Dix <i>Co-Sponsored by Physicians Insurance</i>	February 13 Thursday 5:30 p.m. Beechwood Hotel	224TH ANNUAL ORATION Orator: Sanjiv Chopra, MD, MACP, professor of Medicine, Harvard Medical School, and former dean for Continuing Medical Education, Harvard Medical School Title: Dharma, Health, and Happiness
September 27 Friday 5:30 p.m. Mechanics Hall	WDMS 225TH ANNIVERSARY GALA Celebrating our Society with a display of historic artifacts, music, dancing, and other surprises. Tickets MUST be purchased in advance. <i>For more information and to register</i> 	February 28 Friday 7:00 p.m. Pre-concert Reception; 8:00 p.m. Program; Mechanics Hall	CHANTICLEER Founded in San Francisco in 1978, Chanticleer is known around the world as "an orchestra of voices" for the seamless blend of its 12 male voices ranging from countertenor to bass and its original interpretations of vocal literature, from Renaissance to jazz, and from gospel to venturesome new music.
October 23 Wednesday 6:30 p.m. Leo's Ristorante Worcester	MMS NETWORKING EVENT AT LEO'S RISTORANTE, WORCESTER This is a professional networking event with complimentary hors d'oeuvres, drinks, and good fun! Physician members and non-members are invited and welcome to bring a guest.	March 30 DOCTOR'S DAY March 30 is National Doctor's Day when patients, friends, family, and colleagues honor physicians and express their gratitude for physicians' continuing commitment to patients and exceptional medical care. <i>The event to be announced and will be sponsored by the MMSA.</i>	
October 24 Thursday 5:30 p.m. Beechwood Hotel	14TH ANNUAL LOUIS A. COTTLE MEDICAL EDUCATION CONFERENCE Speaker: Larry Garber, MD, medical director for Informatics, Reliant Medical Group Title: Using the Power of Your Electronic Health Record to Energize Your Practice, Instead of Causing Burnout A generous bequest from the Louis A. Cottle Trust was received allowing WDMS to establish an annual lecture series in memory of Dr. Cottle, a dedicated Worcester physician.	April 15 Wednesday 5:30 p.m. Beechwood Hotel	ANNUAL BUSINESS MEETING Meeting includes presentation of the 2020 Community Clinician of the Year Award.
November 21 Thursday 5:30 p.m. Beechwood Hotel	FALL DISTRICT MEETING AND AWARDS CEREMONY The dinner meeting includes the Dr. A. Jane Fitzpatrick Community Service Award, the WDMS Career Achievement Award, and Medical Student Scholarship Award Presentations.	April–May 30 & 2 Thursday and Saturday 9:00 a.m. Seaport Hotel and World Trade Center, Boston, MA	2020 MMS ANNUAL MEETING AND HOUSE OF DELEGATES All WDMS members are invited to attend as a guest and may submit a resolution to the MMS.
December 6 & 7 Friday and Saturday 9:00 a.m. MMS Headquarters and the Westin Hotel, Waltham, MA	2019 INTERIM MEETING AND MEETING OF THE MMS HOUSE OF DELEGATES All WDMS members are invited to attend as guests and may submit a resolution to the Massachusetts Medical Society (MMS).	May 13 Wednesday 5:30 p.m. Beechwood Hotel	WOMEN IN MEDICINE LEADERSHIP FORUM Speaker: TBD <i>Co-sponsored by Physicians Insurance.</i>
December 19 Thursday 5:30 p.m. Washburn Hall, Mechanics Hall	HOLIDAY RECEPTION AND A NIGHT AT THE MOVIES Join us for a holiday buffet and movie with a group discussion to follow.	May Thursday 5:30 p.m. University of Massachusetts Medical School	MEET THE AUTHOR SERIES Date, Author, and Title: TBD <i>Co-sponsored by the Humanities in Medicine Committee of the Lamar Soutter Library.</i>



For more information about our Society, please visit www.wdms.org.

Health Matters

Health Matters is a television program produced in collaboration with The Worcester District Medical Society and WCCA TV in Worcester. Offering valuable information on disease prevention, treatment options, current public health issues and more, Health Matters is produced in a ½ hour interview format. Our hosts are Drs. James Broadhurst, Michael Hirsh, Bruce Karlin and Lynda Young, and the program airs on WCCA TV Cable Channel 194: Wednesday- Noon and 7:30 pm, Thursday- 7:00 pm and Friday – 9:30 am.

To view past shows, please view our video library: www.wdms.org. In 2020 we will proudly produce our 200th program, and we would like to know what you want to hear more about. If you have an idea for a topic or guest, or wish to be a guest, please contact wordmsa@massmed.org or call 508-753-1579.



Guest: Dr. Alwyn Rapose, Host: Dr. Bruce Karlin Topic: Vaccines.



Guest: Dr. Matthew Masiello, Host: Dr. Michael Hirsh Topic: Climate Change-Health Challenges and How We Can Face Them.



Guests: Dr. Michael Hirsh and Tina Grosowski, Host: Dr. Bruce Karlin Topic: Public Health Response to the Vaping Crisis.



Guests: Deputy Chief Edward J. McGinn and District Attorney Joseph D. Early, Host: Dr. Michael Hirsh Topic: 2019 Gun Buy Back Program.



Many thanks to Frank Rocco, Producer at WCCA TV, for all his hard work and dedication in making our show a success.

Massachusetts Medical Society Networking Event October 23, 2019



Nearly thirty physicians and medical students gathered for a professional networking event at Leo's Ristorante in Worcester. Thank you MMS, we look forward to the next event!

**WDMS Fall District Meeting
Thursday, November 21, 2019
Beechwood Hotel, Worcester, MA**

Congratulations To This Year's Award Recipients

**29th Annual
Dr. A. Jane Fitzpatrick
Community Service Award**



William G. Muller, MD, FACP
*Medical Director/Division Chief,
Tri-River Family Health Center*

**2019 WDMS
Career Achievement Award**



Lucy M. Candib, MD
*Professor, Family Medicine and
Community Health, UMass Medical School*

2019 WDMS President's Award



Edward L. Amaral, MD, FACS
Retired General Surgeon

WDMS Fall District Meeting Thursday, November 21, 2019 Beechwood Hotel, Worcester, MA

WDMS 2019 Medical Students Scholarship Award Recipients

The Dr. Herbert E. Nieburgs Scholarship Award Recipients



Alec Allain
Class of 2022
*University of Massachusetts
Medical School*



Regina Brown
Class of 2020
*University of Massachusetts
Medical School*



Catherine Cattley
Class of 2022
*University of New England
College of Osteopathic
Medicine*



Jamie Horrigan
Class of 2020
Albany Medical School



Jacob Lurie
Class of 2020
*Icahn School of Medicine at
Mount Sinai*

The Reliant Medical Group Dr. M. Elizabeth Fletcher Scholarship Award



Britney Atwater
Class of 2020
*University of Massachusetts
Medical School*

The Milford Regional Medical Center John A. Rauth Book Award Scholarship Award



Kelly Flanagan
Class of 2021
*University of Massachusetts
Medical School*

The Worcester District Medical Society Scholarship Award



Stephanie Hadley
Class of 2020
*Vanderbilt University School
of Medicine*

The Dr. Burte Guterman Scholarship Award



Kelsey Jones
Class of 2021
*University of Massachusetts
Medical School*

The Joyce Cariglia Scholarship Award



Akshay Kapoor
Class of 2020
*University of Massachusetts
Medical School*

The Saint Vincent Hospital Dr. Gilbert E. Levinson Scholarship Award



Kara Kennedy
Class of 2021
*University of Massachusetts
Medical School*

The Dr. Sanfrey Lilyestrom Scholarship Award



Laura Knapik
Class of 2022
*University of New England
College of Osteopathic
Medicine*

The Dr. Leonard J. Morse Scholarship Award



Patrick Lowe
Class of 2020
*University of Massachusetts
Medical School*

WDMS Fall District Meeting Thursday, November 21, 2019 Beechwood Hotel, Worcester, MA

WDMS 2019 Medical Students Scholarship Award Recipients *(Continued)*

**The Dr. Julius Tegelberg
Scholarship Award**



Melissa McCarthy
Class of 2020
*University of Massachusetts
Medical School*

**The Amaral Family
Scholarship Book Award**



Sophia Mercandate
Class of 2022
*Lewis Katz School of
Medicine*

**The Dr. Robert Lebow
Scholarship Book Award**



Mark Poirier
Class of 2022
*Lake Erie College of
Osteopathic Medicine*

**The Dr. Lillian AE Luksis
Scholarship Award**



Pritwijit Roychowdhury
Class of 2021
*University of Massachusetts
Medical School*

**The Joyce Cariglia
and David Williams
Scholarship Book Award**



Michelle Shabo
Class of 2021
*University of Massachusetts
Medical School*

**The Worcester District
Medical Society
Scholarship Award**



Rebecca Kim-Hong Toohey
Class of 2022
*University of Massachusetts
Medical School*

**The Paulette Griffin Pugnaire
Scholarship Book Award**



Vanessa Villamarin
Class of 2021
*University of Massachusetts
Medical School*

**The Worcester District
Medical Society
Scholarship Award**



John Kyle Volpe
Class of 2020
*Zucker School of Medicine
at Hofstra/Northwell*

**The UMass Memorial Health Care
Dr. Samuel Pickens
Scholarship Award**



Palak Walia
Class of 2021
*University of Massachusetts
Medical School*

WDMS Alliance 2019 Nursing Student Scholarship Award Recipient



Lisa McLaren
Class of 2020
*Massachusetts College of
Pharmacy and Health Sciences*



Worcester District Medical Society Alliance

The Worcester District Medical Society Alliance (WDMSA), once known as the Women's Medical Auxiliary, was founded in 1948. The Alliance is an organization committed to the health and wellbeing of our community. The WDMSA has a longstanding history of collaboration with the Worcester District Medical Society (WDMS) in pioneering health initiatives.

Since 1959, the WDMSA has been awarding BSN Nursing Scholarships. In 1966, auxiliary member Gertrude Raymond Perry established an annual donation to the Scholarship Fund in memory of her husband Dr. Albert Orville Raymond.

The need is evident in our community for our nursing scholarship to continue. Through the generosity of our Alliance member's contributions, we were able to sustain a scholarship this year. We would like to thank this year's donors for their support:

Dr. Janet Abrahamian and Arzroon Abrahamian
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 Dr. Stuart and Ludovica Weisberger
 Francine and Rohit Vakil
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If you wish to make a tax-deductible donation to the WDMSA Nursing Scholarship, please make your check payable to Worcester District Medical Society (note WDMSA Nursing Scholarship Fund in memo) and mail to WDMS, 321 Main Street, Worcester, MA 01608.

Thank you for your consideration and continued support.

Worcester District Medical Society Alliance
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http://www.wdms.org/BSN_Nursing_Scholarship.htm



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