Message from FMIG Advisor

Time flies when you are having fun and this fall feels like no exception. The hustle and bustle is upon us with the holiday season, but I certainly want to take time to reflect upon the year to date and make plans for the future. Our fall was chock full and just how I like it. Many groups came together in October to support a widely successful primary care week. Another successful event this fall was our phlebotomy workshop which was both fun and educational. I hope you enjoy this December issue which has two medical students thinking about primary care of the future with the role of nurse practitioners and health coaching and a family medicine faculty member reflecting on a notable patient experience. In general this fall has left me feeling proud to be part of the OSU medical student community. Peace be with you in the coming year.

Allison Macerollo, M

Phlebotomy is FUN!
## Primary Care Week

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- Changing the Image of Primary Care (panel of primary care physicians)
- The Most Vulnerable-Serving the Underserved
- Resident Panel of Primary Care Providers
- Primary Care for Children
- Primary Care and The Affordable Care Act - Universal Health Care Action Network of Ohio Director Cathy Levine

Cathy Levine from Ohio United Health Care Action Network of Ohio discusses the Affordable Care Act

Central Ohio primary care residents discuss why they choose primary care
My Most Memorable Patient

I’ve had many memorable patient experiences but there is one that really stands out. I was working in New Zealand at the time and a nice couple came to see me because she was pregnant and they were really excited about it. She was 39 years old and this was her first pregnancy. She was already almost 18 weeks along during this first visit. As the standard of care dictated, I ordered her blood work, linked her with midwife contacts, and ordered her 18 week ultrasound urgently, as timing was imperative. The following week the ultrasound results came in and unfortunately, there were many abnormalities noted. I discussed the results with the family and made a stat referral to the high-risk Obstetrics team. It was common to not be involved in the prenatal care as this is generally taken over by midwives; but in this particular situation, I had no updates at all and often wondered how she was doing and how her pregnancy was going.

About four months later I received a call from the high-risk OB nurse, not with an update as I’d hoped, but with a very matter-of-fact question regarding pronouncing the baby when it died. Needless to say, I was appalled. I came to find out the baby boy had Patau Syndrome (Trisomy 13) and a very short life expectancy. The family came to see me in the office to discuss this further. Mom was tearful during the visit; dad just held his son and expressed his frustration with the hospital where residents and students wanted to come see his baby, to marvel at all the “abnormalities”. He felt as if his son was on display and this rightfully angered him. Medically speaking it was an interesting case. But this was not a case. These were grieving parents with their first born son. Compassion and respect are so important and no matter the medical complexities involved, we must never forget that they are people first and not just cases. This was not a case of Patau syndrome. This was a baby boy who had Patau syndrome.

I listened and only examined their baby after the father invited me to. He had microcephaly, microphthalmia with fused lids, cleft lip and palate, polydactyly, and a weak grunt. The father was proudest of that grunt. The baby was only expected to live a few days and per the mother’s Indonesian culture, the cremation needed to take place the day the baby passed away. Therefore, he needed to be pronounced by a doctor as soon as possible so they could proceed with the ceremony. It was traumatic that instead of enjoying their first born son and the life ahead of him, they needed to plan for his funeral. I gave them my cell phone number, something I had not done before and have not done since, and told them to call me when needed and I would help them as much as I could. He went quietly one night but had lived about a week longer than expected, which also made his father very proud. I went to their house and did my part, offering this tiny bit of solace so that they could proceed with their customs.

Going into medicine, I never thought that pronouncing a baby was going to be part of my role. Family medicine has provided me many unique, multifaceted opportunities that involve so much more than just the traditional office visit. This bittersweet situation involved the joy of life and the pain of death in a matter of weeks. This family stays with me for many reasons, but to me, this is what real medicine is all about.

Shalina Nair, M.D.
Med Students to Become Health Coaches

The new Lead.Serve.Inspire (LSI) curriculum for first-year medical students has completely redesigned the curriculum. One unique aspect is that students will become health coaches for a patient with chronic disease at their longitudinal practice over a year-long period. They will work with a patient towards a health goal of the patient’s choosing, such as healthy habits, regularly taking medications, or eating more fruits and veggies.

Through this, students will be exposed to the idea of health coaching – creating a partnership with the patient, discovering their values and what drives their behaviors. This coach-patient relationship is based on holistically understanding and respecting the patient. Rada Kuperschmidt, Program Coordinator for Longitudinal Projects at the College of Medicine, calls coaching “getting at the core of the issue” of health problems and habits. It is a process of meeting patients where they are to work on something that is important to the patient, not just what is important to the physician. According to the Director of Health Coaching at OSU Health Plan, Ying Studebaker, key concepts for health coaching include asking open-ended questions and assessing the patient’s own understanding and management of their condition, and their daily struggles with their health. The outcome, Ying stated, is the patient’s commitment to an action-oriented plan with small, manageable steps that they developed with the coach”. She emphasized that ultimately, the patients are in control of their health and are the ones living with and managing their disease, so their involvement in the development of a goal is crucial to success and long-term results.

By acting as coaches, students will be able to develop lifelong communication skills which will enable them to become better physicians. By asking open-ended questions and caring for patient’s entire lives, these future doctors will be able to connect with patients, personalize treatment plans for the patient, and encourage patient participation in their own healthcare. Rada shared that from her personal experience, language, communication methods, and compassion made an enormous difference in how she perceived different doctors’ visits and how likely she was to follow through with their suggested treatment plans.

Dr. Donald Mack, Assistant Clinical Professor of Family Medicine at OSU, shares that he hopes this project will excite students about primary care and coaching, and will help students understand and value these roles as a part of the care team. Right now, health coaching is almost exclusively used in primary care and especially in Patient-Centered Medical Homes (PCMHs) for chronic disease management. As reimbursement is increasingly being tied to how well practices take care of their patients as a whole, Dr. Mack expects coaches to become a cost-effective solution to disease management. This program will allow students to become familiar with coaching, as they may be primary care physicians working with coaches, or they may be specialists whose patients are working with a coach at their PCP for a health issue. This early exposure to a novel concept in primary care is just one unique feature of the OSU College of Medicine’s improved curriculum. The end goal of this project is for the students to work with patients to make small steps toward small changes which will ultimately change lives.

Kelsey Murray, Med 1
Nurse Practitioners in Primary Care

In the 1960s, as primary care physician shortages threatened the health of the nation, the position of Nurse Practitioner was developed to address health care needs. Currently, nurse practitioners make up approximately one sixth of the health care workforce, and are employed in almost 25% of primary care practices. However, there has been some debate about the role of Nurse Practitioners (NPs) in these practices. Some question whether they are being utilized to their fullest potential, while others believe that diagnosing and treating patients independently of physicians is overstepping the bounds of nursing practice. Physicians and nurse practitioners have different training backgrounds, but share a common goal of improving patient care and outcomes. The point of contention is on how best these two specialties can work together to achieve this goal, and is yet to be determined.

Currently, an RN degree and subsequent Master’s degree are required to become a Nurse Practitioner. However, it is expected that in the next few years a DNP (Doctor of Nursing Practice) degree will be required for all NPs. The American College of Physicians states that while they fully support the movement toward requiring doctorates for NPs, the further education does still not equate NPs to physicians in terms of training. The ACP compares the 1,000 clinical hours and one year residency program required in the DNP program to the 3,200 hours of clinical education in medical school and the 3 year residency in a specialty, with the conclusion that “NP or DNP degree does not prepare NPs to perform in the same capacity as physicians.” Similarly, the American Medical Association proposes that the seven plus years of post-graduate training and over 10,000 hours of clinical experience of physicians far outweighs the training of NPs. However, a study in the Netherlands that looked at patient outcomes (morbidity, mortality, satisfaction, compliance, and preference), found no difference in outcomes between services provided by appropriately trained nurses and services provided by primary care physicians. Many other studies have reported similar results. It is argued that for most patients in a primary care setting, the extra training of physicians is not necessary to provide quality health care.

The regulation of services provided by NPs varies from state to state, with 22 states allowing for NPs to practice independently, without any physician involvement in provision of care. In most of the rest of the states, NPs must be supervised by a physician, but there is no requirement for the supervising physician to be present during patient encounters. In all 50 states, NPs are allowed to prescribe medications, but some states have regulations on prescribing controlled medications. There is some debate about which states have it right and which states have it wrong, in terms of regulation of NP responsibilities. The American Academy of Family Physicians released a position statement stating “the nurse practitioner should not function as an independent health practitioner.” Similar positions are held by the AMA, American Osteopathic Association, and the American Academy of Pediatrics. These organizations state that the extensive training and clinical experience of physicians is necessary for optimal patient outcomes, and that NPs should function solely as part of a physician led team. Others argue that states should allow for more independence of NPs citing states’ regulations as the “critical factors limiting nurse practitioners’ capacity to practice to the full extent of their education, training, and competence.” The American Academy of Nurse Practitioners (AANP) responds to the position of the AAFP, stating that this position is “directly contrary to the recommendations of the Institute of Medicine and the National Council of State Boards of Nursing.” The AANP states that over 100 studies have shown that NPs have equal or better patient outcomes compared to physicians, and claims that attempts to limit NPs abilities to practice is to the detriment of Americans who need access to health care.

“Physicians and nurse practitioners have different training backgrounds, but share a common goal of improving patient care and outcomes.”
Nurse Practitioners cont’d

Utilization of NPs more fully in the health care system could also have significant monetary benefits. It is suggested from a study in Massachusetts that using non-physician health care providers such as NPs and physician assistants to their fullest potential would save that state between 4.2 and 4.8 billion dollars over ten years. It is also estimated that anywhere between three and twelve NPs can be educated at the same cost to educate one physician. While cost should not be considered over the quality of care provided, if patient outcomes are similar it would be extremely beneficial for the government to invest in NP training. Additionally, NPs are reimbursed at only 85% of physicians’ rates for services provided, therefore it is less expensive to pay for health care provided by NPs.

The regulations of NP duties vary from state to state and practice to practice, from managing patients’ care independently to not managing patient care at all. It seems as though the recommendations for NPs seeking employment is to find a practice which suits their abilities. One NP claimed she was asked to manage cases which were outside her area of knowledge, and therefore was thinking about leaving her position. Another was being underutilized, taking notes for a physician and educating patients instead of managing patient care. With NPs’ independence in diagnosing and treating patients comes liability for their decision making. Therefore, it is in their best interest, as well as the best interest of patients, to manage cases that lie in their scope of training.

All evidence seems to point to increasing the independent role of NPs, as a way to increase access to quality health care and decrease health care costs. It seems as though our primary care system is leaning toward independent functioning NPs, and many practices have already incorporated this style. Lindsey Weisbecker, a Nurse Practitioner at OSU has her own subset of patients she diagnoses and treats independently. She believes that the RN degree, clinical experience, and standards set for national certification and licensure ensure that adequate training is provided for NPs to function in their capacity. Why, then, do physician organizations insist that NPs should not provide care independently of physicians? In order to clearly prove that the patient outcomes between NPs and physicians are equal, there needs to be stronger and more compelling evidence. The AANP fails to cite which studies showed equal patient outcomes from NPs and physicians, and the study from the Netherlands was done in 2005 and had a limited data set. It is obvious that physicians have more training than NPs, but what needs to be more clearly demonstrated is whether that additional training is absolutely essential to provide adequate care in the primary care setting, or in what instances is that training crucial for patient care.

Clearly there must be a compromise when it comes to roles of NPs in primary care. It remains to be determined in what capacity this compromise will be, and whether legislature will expand or limit the independence of NPs. Nurse practitioners currently play integral roles in many primary care practices, and it is key for all members of health care teams to work as a team for the benefit of the patient. It will be interesting to see whether the roles of each team member changes in the coming years, and what impact this change will have on the field of primary care.

Maradith Noonen, Med 2
Summer Externship

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Improve skills of physical exam

Improve skills of patient interviewing

Improve skills through observation and direct experience

Appreciate that Family Medicine is a satisfying and rewarding career

A stipend of $1000 is offered for this program

Session 1:
June 10–July 5, 2013

Session 2:
July 8–August 2, 2013

Deadline is January 31, 2013!
Application can be found on The OSU Family Medicine Website
www.fammed.ohio-state.edu/

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