As we approach the holiday season I am always struck by the amount of charitable giving that occurs during this time. I fully support charitable giving and find myself sending supplies for homeless shelters to my children's school, giving food and money to the food pantry in our town and completing my pledge for donations through my paycheck. I certainly feel that I have enough, really more than enough to provide for my family. I believe that this charitable giving is important, and an important lesson for my children as well. However I am always thinking about how we provide for persons in need throughout the year. When I examine this statement I consider how and what I do to provide my best for those in need every day of the year. I believe that this charitable giving is important, and an important lesson for my children as well. However I am always thinking about how we provide for persons in need throughout the year.

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Recently I was thinking about communication and care coordination and I am able to reference two wonderful exchanges I had with different care team members over the past weekend regarding my patients. I spoke to a physical therapist who wanted to know more about a patient's ability to function prior to her recent stroke and feel with our conversation helped her care as we planned an intervention focused on safety for the patient. I also had an email exchange with a neurologist about a mutual patient and her risk of herpes zoster related to her medications. These pivotal conversations are and should be daily and help me to believe that when we continue this communication we are all working together to provide excellent care. Overall I have been describing many aspects of the Patient Centered Medical Home (PCMH). I function in a patient centered medical home and to fully understand how all the members of my team work together I thought they could describe a little bit about what they do and how they function. Whatever you think about patient centered medical home it surely represents the future as we must work together to provide coordinated, best practice driven care which is paramount for our patients and lowers costs to society. “The 21st-century paradigm is that of physicians who understand teamwork and systems of care in which they can provide leadership. Group practice, both virtual and real, will allow the support of information systems, the collection of evidence about care, and efforts for continuous quality improvement health care quality and how to achieve it.” Shine KI. Health care quality and how to achieve it. AcadMed. 2002 Jan;77(1):91-9.

In the pages to follow see what our patient advocate, mid-level provider and pharmacist all do on a day to day basis. Please recall that my direct team also has a nurse, nutritionist medical assistants and office personnel. I function to provide direct care to patients and coordination of care as well. I can assure you that I am never bored and always feel called to do better for my patients. Enjoy this holiday season and look inside this newsletter for more information about summer externships for Med 1 students looking for clinical experiences.
Patient-Centered Medical Home

Current state of the U.S. health care system
- Ranked 37th in quality by the World Health Organization
- Spends more per capita than any other nation in the world
- 20% to 30% of patient tests and procedures are unnecessary and not beneficial

PCMH: The Future of Primary Care
The Patient Centered Medical Home (PCMH) is the future of primary care in the United States. Through a personal family physician, comprehensive care is coordinated and individualized to deliver better health outcomes such as:
- ↓ mortality and morbidity
- ↓ medication use
- ↓ per capita expenditures
- ↑ patient satisfaction
- ↑ greater equity in health care

Practice Organization
A strong practice functions best with effective financial management, team-based care, and updated clinical systems such as e-prescribing and patient registries.

Health Information Technology
HIT in family medicine means information sharing and communication among providers, evidence-based medicine and greater access to clinical data.

Quality Measures
Growth is ensured in a culture of improvement where performance is measured using data and reliable collection tools.

Patient Experience
Patient-centered means doing what’s right by and for the patient, as in convenient access, shared decision-making, and group visits or e-visits that are personalized.

Family Medicine

fmignet.aafp.org
I don’t like blood, vomit, or touching people. Things that ooze, flake or puss gross me out. Given those descriptions, you can imagine that being a nurse or a physician would not have been a good career choice. So what could I study that would allow me to have an impact on a patient’s health and quality of life, without having to experience the above mentioned things? For me, the answer was pharmacy.

I received my Doctorate of Pharmacy from the Medical University of South Carolina College of Pharmacy. During my final year of pharmacy school, I came to Columbus to stay with my sister and complete 2 rotations. My first rotation was a potpourri of experiences. During this month, I shadowed several pharmacists at University Health Connection clinic at OSU. This interdisciplinary clinic demonstrated the team approach to personalized patient care, and the impact a pharmacist can have as a part of the team. As a result of my experience, I chose to pursue a residency following graduation.

Unlike physicians, pharmacists are not required to complete a residency. However, those wishing to have more involvement in direct patient care usually complete a one or two year program. I completed a Pharmacy Practice Residency with an Emphasis in Community Care, focusing on patient education and disease management. Following residency, I moved to Cincinnati and began my career in a grocery store pharmacy. I was a staff pharmacist (filling prescriptions) two days a week and a clinical pharmacist three days a week. Unlike retail store clinics staffed by a nurse practitioner or physician assistant, my clinic was attached to the pharmacy. I saw patients with diabetes, hypertension and/or hyperlipidemia, serving as a "pharmacist coach" for a disease management program sponsored by a large employer group. I had 70 patients whom I managed, educating them on disease processes and medications, as well as goal setting to achieve the standards of care for their specific disease states. I saw each patient every one to three months, and I can truly say that every patient had an impact on the way I practice today. While I enjoyed my job, there was one piece missing...true collaboration with the physicians.

This desire for collaboration led me to my current position as a Specialty Practice Pharmacist with the Primary Care Network at Ohio State. I work in 5 family medicine offices around Columbus. In my position, I have several roles. I am in a resident clinic 70% of my time. This allows me to serve as a pharmacotherapy and medication resource for all learners, including physicians, students and staff. The second part of my role involves being a provider in the patient-centered medical home. Physicians are able to refer patients to me for help with non-compliance, disease management and medication management. Unlike a physician visit in which multiple health issues need to be discussed, I am able to focus on one or two specific conditions or medication-related issues. I educate the patient on the disease state and what is happening in the body, how the medications work, and the importance of compliance. Patients set goals for future visits, allowing them to take an active role in their healthcare. Since I am collaborating with the physician, I am able to request labs, recommend medication changes, and provide follow-up in a timely manner. Depending upon the situation, the patient may have a one time appointment, or may follow-up with me every 2 weeks – 3 months. With this follow-up, the patient’s goals are assessed over time to help achieve the standards of care and improve the patient’s quality of life.

Now that you know what I can do, what do I love to do? My passion is diabetes education and management. I have found that with a better understanding of what is happening in the body and how medications work, patients increase compliance with multiple aspects of diabetes management. After 3.5 years of accumulating hours, I will be taking the Certified Diabetes Educator (CDE) exam in the spring. Having this certification will allow increased opportunities for patient care within the patient-centered medical home and will more fully demonstrate the value of a multidisciplinary family medicine practice.
Summer Externship

This program pairs an Ohio State University medical student between his/her first and second year of study with a family physician in a rural or urban setting.

Experience unique aspects of problem solving and decision-making

Improve skills of patient interviewing

Improve skills of physical exam

Improve skills through observation and direct experience

Appreciation of Family Medicine as a satisfying and rewarding career

Deadline is January 31, 2012!

Application can be found on The OSU Family Medicine Website familymedicine.osu.edu

Return to Amy Peters B0902B Cramblett Hall 456 W. 10th Ave. Amy.Peters@osumc.edu

A stipend of $1000 is offered for the program

Session 1: June 11 – July 6, 2012

Session 2: July 9 – August 3, 2012
The reality of having to choose between purchasing medications or food for the month is very real and something I see with our patients everyday. Fortunately, for many of those patients I can help make this decision easier by assisting them with prescription assistance. Most major drug manufacturers have prescription assistance programs available for name brand medications and offer those free of charge for patients who qualify. This very large aspect of my job is by far also the most rewarding. Many patients are not aware these programs exist so having an advocate inside their doctor’s office makes the application process simple and often as easy as one signature. Navigating social resources including housing, utilities, transportation and other daily living needs can also be a frustrating system for patients and being to help with this sometimes small task can make a major difference. I recently had a patient in our Gahanna office that was uninsured with several uncontrolled co-morbidities and severe depression, which was directly related to her declining health, and hadn’t been in to see her doctor in nearly a year. My first step was getting her financial aid approved, and quickly. We then scheduled her with her physician and got this patient started on prescription assistance for her medications including her insulin, anti-depressants and any that were not covered by prescription assistance I was able to establish her with the Charitable Pharmacy here in town which then covered the rest of her medications. The patient has also been able to establish care with our Pharmacist and Dietician. My last phone conversation with this patient she sounded wonderful and said she hadn’t felt this good in years and expressed sincere gratitude to her entire healthcare team. She never knew about all the wonderful resources and expertise within our offices and now has said she feels like her life is back on track. This story is only one of many which exemplifies the importance and magnitude of Patient Centered Medical Home and each of our roles in it.
With a nationwide shortage of primary care providers, specifically family physicians, Nurse Practitioners are playing an increasingly important role in trying to meet the needs of Americans seeking healthcare access. Unlike a physician assistant, nurse practitioners (NP) can and do treat patients independently with a collaborative relationship established with physicians for consultative purposes. Even though NPs and family physicians can and often do work independent of one another, I am fortunate as a NP to practice at the OSUMC where our skills are seen as complementary, not competitive with physicians. Our numbers bear out this complimentary environment, since just a few short years ago there were only a small handful of NPs practicing inside the family medicine offices. Today the number of NPs working along side family physicians, or in the other family medicine sites has grown tremendously.

Key to this growth has been the development of highly effective collaborative relationships between on-boarding NPs and OSUMC physicians. It requires a mutual respect and clearly defined NP expectations that are communicated between both providers at the beginning of the NP’s tenure, regardless of practice setting. Building a strong working relationship with any collaborating physician begins with a clear understanding of the NP role and the NP’s scope of practice. Once this is completed, both parties sign off on a document called a Standard Care Agreement (SCA), outlying these details. A lack of clear role definition or unclear MD expectations of the NP are cited as the single greatest barriers to NP and MD collaboration. This basic mutual understanding is the key to a successful practice environment. So it is essential that an effort be made early in the development of a working relationship to meet the needs of the providers, the practice and patients.

NPs have played a role within the health care system for most of the past century. The profession has grown in recognition as evidenced by ever expanding prescription and reimbursement privileges. NPs hold a wealth of advanced knowledge that has allowed them to practice in an arena once previously restricted to physicians. The ability of NPs to work collaboratively is a reflection on their profession and educational background. Indeed, the topic of faulty collaboration on the part of NPs and physicians is not new; it is an area that both of these providers face in everyday working relationships. Knowledge and understanding of the barriers and consistent use of strategies, such as the development of clear and understandable Standard Care Agreements, will help to develop lasting interprofessional relationships that will ultimately positively affect patient outcomes. After all, patients benefit from a team that accepts and respects each other’s role and essentially each other’s profession.
Vicki Marie from ODH alongside Dr. Shivonne Suttles spoke to the Family Medicine Interest Group about scholarships and programs available through the National Health Service Corps.

You can learn more by visiting:
http://nhsc.hrsa.gov/
Thank you!

FMIG appreciates the financial support of the Columbus family medicine residencies:

- Grant
- Riverside
- Mount Carmel
- OSU

Thank you!

FMIG appreciates the continued financial support of the Central Ohio Academy of Family Physicians.