The Christ Hospital – University of Cincinnati Family Medicine Residency Training Program

First Five Years in Review
&
Mapping the Future

Recognizing what we have done in the past is a recognition of ourselves. By conducting a dialogue with our past, we are searching how to go forward.
Kiyoko Takeda

A Report to The Christ Hospital Administration

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Introduction: Purpose of the Report & Thank You

Family Medicine has completed five years at The Christ Hospital, and it is timely to evaluate the impact of this relationship on the hospital. By doing so in the early part of the report, opportunities for the future come to the surface, and those opportunities are discussed in the final section.

This report has multiple purposes:

1. Document the value of the Family Medicine Residency Training Program to The Christ Hospital; review the costs and benefits of the program to the institution.
2. Summarize the Program Performance of the first five years at TCH and identify program strengths and weaknesses that will help define future opportunities.
3. Present future role/scenarios for Family Medicine at TCH as a guide for strategic planning.
4. Provide a full picture of what Family Medicine is and who the key people are in Family Medicine at TCH.

Suggestions for reading the report. The report is lengthy but the intent is to provide sufficient detail to support some of the conclusions and recommendations in the executive summary. It is best to start with the summary to get a brief overview and then go to the specific section for a fuller discussion. Page numbers are highlighted in the summary for ease of navigation.

A Note of Thanks. Now in our 6th year at TCH I have come to realize that it is one of America's great hospitals—and the reason is its culture. Culture begins with the Board of Trustees and the Hospital Administration, particularly Susan Croushore and her administrative team, and filters down into the associates and staff. The vision is to be a top 10 hospital by 2010. I have no doubt that that will be reality. We are thankful to be part of this great hospital and contribute to its mission in some small way. Finally a note of thanks to Jeff Susman, MD, our Department Chair, for his ongoing support of the program.

Phil Diller, MD-PHD
Program Director, TCH-UC Family Medicine Residency Training Program

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Executive Summary & Action Steps

Key Summary Points

1. The Family Medicine Residency Training Program at The Christ Hospital (TCH) has contributed positively to TCH's mission and has generated net revenue for the hospital in the first five years. This is seen in the additional GME revenue, increasing volume of inpatient admissions, the downstream revenue generated from its offices, and the relationships with referring community family physicians.

2. Partnership with UC Department of Family Medicine expands TCH's Community Benefit through the various clinical and educational services provided by the Family Medicine Residency Training Program.

3. TCH is poised to become the regional leader in driving innovation and quality for primary care that in turn will improve the health of the community. A TCH Primary Care Foundation would strengthen the relationships between TCH and the community primary care physicians and should be seriously considered.

Detailed Summary Points

A. Program History, Value of Primary Care to Community Health and Program Strength

1. The Family Medicine Residency Training Program (FMRTP) came to The Christ Hospital (TCH) in July 2003. TCH became the sponsoring institution for the FMRTP in February 2005 **[page 8]**

2. Family Medicine is not a Business, but rather a Social Good. The FMRTP is a social good whose value is not in generating large profits directly, but rather in contributing to TCH's community benefit, extending and expanding TCH's impact on the community, and producing "downstream" revenue for the hospital. **[page11, 20-29, Appendix 1 & 2]**

3. TCH promotes the health of the community by partnering with UC Family Medicine to provide Family Physicians for the community. Evidence shows that primary care promotes the health of a community through 6 mechanisms: 1) *increases* ***access*** *to health services for relatively deprived population groups*, 2) *offers high* ***quality, coordinated clinical care***, 3) *promotes* ***prevention***, 4) institutes ***early management of health problems,*** 5) *when primary care characteristics are implemented comprehensively they* ***lead to more appropriate care***, and 6) *effective primary care* ***reduces unnecessary or inappropriate specialty care***. **[page11]**

4. Program Personnel are Exceptional and Attract High Quality Trainees. One of the key assets of TCH-UC FMRTP is the program faculty who possesses strong leadership skills, are excellent clinicians, and who have been recognized as outstanding teachers. Strong faculty role models attract strong residents who in turn become strong clinicians and faculty. This creates a vibrant program culture and contributes to strong medical staff when these clinicians join the TCH medical staff. **[pages 11-15 and Appendix 3 & 4]**

5. The FMRTP Global Health Program and the combined Family Medicine-Psychiatry Program are nationally recognized enrichment experiences/paths for trainees. [page 15]

B. Program Educational Outcomes (Grades are an internal, self-evaluation and suggest opportunities for improvement):

1. **ACGME Accreditation. (B)** Last accreditation was for four years with key citation being the distance and size of the Forest Park Family Medicine Center. **[page 15]**
2. **Residency Recruitment. (D)** Since moving to TCH the program has filled through the match only two out of five years, and fails to consistently match top UC COM students entering into Family Medicine. **[page16,17]**
3. **Resident In-Training Examination Scores. (A)** Third Year residents' average scores as a group for the last 7 years is in the upper 15% of all tested. Residents show consistent improvement in their individual scores as they progress through the program. **[page17,18]**
4. **ABFM Passing Rates. (A)** 100% Pass rates for all family medicine residents and family medicine-psychiatry residents who choose to practice family medicine. **[page 18]**
5. **Program Evaluation by Trainees and Faculty. (B+)** Resident overall satisfaction with the program, strength of faculty, Leadership, International Health Experiences, and TCH is quite high and >95% would choose the program again. However, there remains selected rotation experiences and the Forest Park FMC experience that are rated low and can be improved. **[page18]**
6. **The program consistently produces well trained FPs who choose diverse career paths. (A)** 51% of graduates stay in the Greater Cincinnati Area (18 in the last five years); 14% practice in rural community with a broad scope of practice including OB and hospital work; 37% have academic careers; some choose to practice in an inner city setting and a small subset work overseas. **[page19]**

C. Value-Added to TCH:

1. **Hospital Downstream Revenue from the Partnership.** Using reported methodology for the multiplier effect of family medicine offices and geriatric practices on hospital revenues, the partnership with UC Family Medicine generates a conservative estimate of **$19M to $38M annually** in hospital charges to TCH (using different assumptions generates the range). [page20]
2. **Qualifying for Disproportionate Share Hospital (DSH) Payments.** TCH has consistently qualified for DSH payments **(average additional annual revenues = $2.3M)** for reaching a threshold of indigent care since Family Medicine began admitting patients to TCH (4 for 4 years compared to 1 in 3 in the years prior to Family Medicine arriving at TCH). [page 21]
3. **Family Medicine Hospitalist Service for Community Family Physicians.** The Family Medicine Inpatient teaching service functions also as a hospitalist service for community Family Physicians. In the first five years the number of annual admissions have nearly doubled from 540 to 961. Unexpectedly, by the 5th year the number of admissions from community FPs is now greater than the admissions from UC Family Medicine sources. Over the first five years the number of admissions from Forest Park and the Geriatric group has doubled. Satisfaction by patients and community physicians is very good to excellent. **[page 22]**
4. **Family Medicine Obstetric Service.** The number of patients delivering at TCH who originate from the family medicine offices continues to increase over the first five years and is about 3.5% of all deliveries at TCH. The total number is below the goal of 280 (8% of TCH total). The MOB Prenatal clinic contributes to the hospital's community benefit; **[page 23]**
5. **Family Medicine Recruitment of Family Physicians who use TCH as their primary hospital.** When the UC Department of Family Medicine came to TCH in 2003 it brought a department with ~22 MD

faculty members. Over the first five years the department has now grown to 28 MDs; 7 graduates who have joined the department. A new TCHMA Family Medicine office has opened in November, 2008. **[page 25]**

6. **Membership and Participation on Medical Staff Hospital Committees.** The department has multiple faculty members on who are various hospital committees, including the Medical Executive Committee, The Performance Improvement Council and number of clinical committees. These individuals represent future leaders and social capital for the hospital. **[page 26]**

7. Recognition for TCH Through the Accomplishments of Program Personnel. Many faculty have been recognized locally, and at the state and national levels for teaching and clinical expertise and for community service. **[page 27, and Appendix 3 &4]**

8. **Partnership/Relationships with other institutions and community physicians.** UC Family Medicine creates a link for TCH between the UC COM, Alliance Primary Care, and Greater Cincinnati Health Foundation at a time when the regional health system politics are challenging. In addition, due to the placement of 92 graduates in the Greater Cincinnati area over the past 30 years the department also has strong ties to the community FPs. These relationships are an asset to TCH and are one of the contributing factors for the growth of inpatient volume. These relationships have the potential for greater leverage for TCH missions. **[page 27]**

9. Extending the care mission of TCH beyond the hospital walls and out into the community. **[page 28]**

D. Program Costs to TCH.

1. GME Revenues. TCH receives on average **$10.5M from CMS annually** for all GME activity; Family Medicine portion is estimated to be about **$2.8M** in FY09. **[page 30]**

2. TCH contract support for Family Medicine is about **$2.4M**; 41% for resident salaries and 59% for program administration, teaching, support of a portion of clinical services. **TCH has generated a positive contribution margin** based solely on the GME reimbursement over the first five years. **[page31]**

3. TCH has **saved institutional costs** for recruitment of family physicians who now are TCH medical staff (estimated $350-700K in the first five years), and for staffing the Family Medicine hospitalist service. **[page32]**

4. TCH has saved on typical Hospitalist's costs for the Family Medicine Hospitalist Service. **[page 32]**

E. Recommended Action Steps for the Future for Family Medicine at TCH

1 New Family Medicine Center on TCH Campus and Increased Contractual Alignment with TCH. [page 33]

Improve resident recruitment, grow family medicine at TCH with a TCHMA Family Medicine Center for training Family Physicians, growth of partnership with TCHMA to place graduates in TCHMA offices, Department offices that are TCHMA offices.

i. Create a new Family Medicine Center for Residency Training on the TCH Campus that is a TCHMA office; Grow the new MOB Family Medicine TCHMA practice.

ii. Facilitate graduates joining TCHMA offices in the community.

iii. Improve Maternity Care Training in the Family Medicine Residency on TCH Campus; support an obstetrician in the Department of Family Medicine.

iv. Create new curriculum focusing on the emerging trends in medicine—to be at the advancing edge of medical education.

2. Establishment of a Primary Care Foundation at TCH to Develop High Quality Primary Care, Seek to Proactively Improve Community Health, and Be Recognized for Leading Innovation in Primary Care Practice in the Region. [page 36]

i. Create Primary Care Foundation at TCH: seed with funds from Elizabeth Deaconness Gamble Home Association; annually direct a portion of GME monies to continue to fund the foundation to a target goal and for annual expenses in beginning years.

ii. Build Foundation infrastructure to support monitoring health of populations, improving quality of primary care in TCHMA offices, innovation in primary care (e.g.,

patient centered medical home), and create loyal relationships between TCH and community Primary Care Physicians.

iii. Support primary care and geriatrics education.
   a. Endow a "Pre-doc" chair at UC Department of Family Medicine
   b. TCH Primary Care Medical Student Scholar. $25K Scholarships for 2 4th year UC-COM medical students; linked to joining a TCHMA Primary Care Office.
   c. Support of Palliative Care-Geriatrics Fellowship Program

A. Program History and the Community Need for Family Medicine

1. How Family Medicine Came to The Christ Hospital and Trends in Primary Care at TCH

The Christ Hospital (TCH) is Cincinnati's leading adult hospital with a long tradition dating back to the late 1800's of providing high quality health care for the Greater Cincinnati community. It has garnered numerous awards, e.g., perennial inclusion on the US News and World Report best hospitals list, recently within the top 40 for patient safety by the LeapFrog Group. In the past two years the hospital has embarked on the mission of being included in the top 10 hospitals in the United States by 2010.

TCH has had Graduate Medical Education (GME) as part of its mission since the 1970s. It has sponsored a program in internal medicine and has also partnered with the University of Cincinnati College of Medicine (UCCOM) with residents from other specialties who rotate through TCH for training. TCH also sponsors the Geriatrics fellowship program that is overseen by the Geriatrics Division at UCCOM. Prior to 2003 there were only a small number of family physicians who admitted to TCH.

Chronological Milestones at TCH

Year 1
July 2003. Created new Adult Inpatient Service and OB service at TCH.
June 2004. 12 Graduates

Year 2
September 2004. Moved administrative offices from Wyoming store-front to TCH-MOB Suite 340.
June 2005. 9 Graduates

Year 3
July 2005. TCH assumes GME sponsorship of Family Medicine Program; name changed to The Christ Hospital/Univ of Cincinnati Family Medicine Residency Program
April 2006. Prenatal Clinic opened for self-pay, Medicaid patients
June 2006 7 Graduates

Year 4
September 2006. TCH creates a new medical staff Department of Family Medicine
June 2007. 4 Graduates

Year 5
June 2008. 6 Graduates

Year 6
November 2008. New TCHMA Family Medicine office opens in MOB on TCH Campus

An Opportunity for Family Medicine at TCH. The Department of Family Medicine at the University of Cincinnati started in 1974. From 1974 to 1993 the Residency program was based at University Hospital. In 1993 the program moved to Providence Hospital which later became part of the Mercy-Franciscan system. In 2002 the hospital leadership at Mercy-Mt. Airy decided they no longer wished to have GME activity in the hospital and asked the program to relocate. With the assistance of the GME leadership in the Health Alliance and the University of Cincinnati College of Medicine, The Christ Hospital agreed to temporarily house the program beginning in July, 2003 until a more permanent solution could be created. Under GME rules for transferring residents, the program closed at Mt. Airy, and the resident positions were transferred to The Christ Hospital on a temporary basis; the program downsized from 40 residents to eventually 17 residents. This downsizing lead to a re-design of the program, relocation of the Family Medicine Center in Forest Park, and with all the changes, a more challenging recruitment of residents into the program. After the first year-and-a-half the

hospital recognized that the Family Medicine training program was bringing value to the institution, and in July, 2005 TCH assumed full sponsorship of the program.

Environmental Context	
Composition of Primary Care Medical Staff at TCH	**Need for Family Medicine at TCH.** At the same time the program moved to TCH, a growing need for primary care also was increasingly being recognized across the country. What is the projected need for primary care at TCH? At TCH in 2006 there were 156 primary care physicians on the TCH medical staff (active and courtesy) consisting of 91 General Internists and 65 Family Physicians. In 2005, the number of hospital discharges by area of Hamilton County correlated with the number of primary care physicians in those areas. By 2015 nearly 40% of this primary group would be 60years of age. Thus, there is an aging primary care workforce for TCH underscoring the need for more primary care physicians to maintain the access to care and market share for the hospital.
Rise of Hospitalists; changing relationships between hospitals and PCPs	Another recent development in medicine is the decline in primary care physicians doing hospital care and the increased utilization of hospitalists. This trend is changing the relationship between the hospital and the primary care physician. How the hospital relates to the community physicians and facilitates coordination of care will increasingly be a higher priority. Having collegial relationships between physicians based at TCH with physicians in the community is essential to TCH's future.
Decreasing numbers of Internists becoming PCPs	In addition, training in primary care for internal medicine has also experienced a decline as fewer and fewer internal medicine graduates were choosing general internal medicine as a career path. Thus, the opportunity for TCH to have its own Family Medicine program provides a complement to the internal medicine program for placing primary care physicians with strong ties to TCH. The hospital has recently launched its primary care group, The Christ Hospital Medical Associates (TCHMA), and this is a vehicle that is poised to drive quality and innovation in primary care in the region.

2. Family Medicine's Uniqueness as a Primary Care Specialty and its Place in Cincinnati Medicine: *Program Structure For Training*

This section defines primary care, describes how family medicine is unique, and lists how primary care is of value to a community's health.

Family Medicine is one of the primary care specialties that fulfills the Institute of Medicine definition for primary care:

*Primary care is the provision of **integrated**, **accessible** health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a **sustained partnership** with patient, and practicing in the **context of the family and community**.*

Institute of Medicine. Donaldson JS, Yordy KD, Lohr KN, Vanselow NA, eds. **Primary Care: America's health in a new era.** Washington, DCL National Academy Press, 1996.

The ACGME Residency Review Committee for Family Medicine defines the curriculum requirements for training family physicians and this differentiates Family Medicine

from other primary care specialties: general internal medicine (adults) and general pediatrics (children). Family Medicine physicians or Family Physicians differ from these primary care specialties not only in seeing patients across all ages of the life-cycle, but also in approach to the patient (multiple contexts including social), appreciation of patient psychological concerns, emphasis on prevention, extent of care of women including obstetrics, and office procedural training. One of the critical settings for family medicine training is the primary care office, also called the Family Medicine Center. Residents in family medicine as they progress through the program spend increasingly more of their time in the FMC; in the first year ½ day per week is in the FMC compared to 3 to 5 ½ days in the third year. The other primary care specialties, general medicine and pediatrics, do not have this increasing ambulatory requirement Appendices 1 and 2 pictorially represent the basic differences between the various primary care specialties (1) and the principles of family medicine (2).

Table 1 includes the following rotation requirements for family medicine training as required by the RRC and where they are done in Cincinnati. Hospital based medicine is emphasized early in the training program in order to learn the steps of the clinical method as applied to common inpatient problems. In addition, residents learn how to organize and coordinate care for multiple, very sick patients—this occurs for medical, surgical, obstetrical, pediatric, and critically ill patients in the hospital and in the emergency room. These broad experiences provide a solid foundation for future ambulatory practice, and also hospital work.

Curriculum Rotations	Required Months	Location in Cincinnati
Family Medicine Service Adult Medicine	6	TCH
Critical Care	1	TCH
Cardiology	1	TCH
Geriatrics	1 & longitudinal	Maple Knoll Village
Emergency Medicine	1	UH
General Surgery	2	TCH and various office
Surgical Subspecialties Otolaryngology (ENT) 1 Opthalmology 1 Orthopedics 2 Urology 1	5	Community Offices
Obstetrics & Gynecology	3	Good Samaritan and TCH
Pediatrics (Inpatient, Clinics, Newborn, Emergency Medicine)	4	Cincinnati Children's & Univ Hospital
Dermatology	1	Community offices, VA Hospital
Sports Medicine	1	Community offices
Behavioral Medicine	Longitudinal	TCH, Forest Park FMC
Community Medicine	Longitudinal & 2	Various settings-local & international
Radiology/Nuclear Medicine	Longitudinal	TCH
Health Systems Management	Longitudinal	TCH, Forest Park, Community offices
Family Medicine Center Ambulatory Practice	Longitudinal	Forest Park FMC
Conferences	Longitudinal	TCH, Forest Park FMC, Maple Knoll Village

Value of Primary Care. Family Medicine as a primary care specialty has significant impact and value to the health of a community; the evidence for this is quite compelling and has been reviewed by Barbara Starfield, a leading public health researcher from Johns Hopkins University.[1] Is primary care health promoting? And if so, through what characteristics or aspects of that care? According to Starfield, "The evidence shows that primary care helps prevent illness and death, regardless of whether the care is characterized by supply of primary care physicians, a relationship with a source of care, or the receipt of important features of primary care. The evidence also shows that primary care (in contrast to specialty care) is associated with a more equitable distribution of health in populations, a finding that holds in both cross-national and within-national studies." She offers 6 mechanisms by which primary care produces its health promoting effects:

1) increases **access** to health services for relatively deprived population groups,
2) offers high **quality, coordinated clinical care**,
3) promotes **prevention**,
4) institutes **early management of health problems,**
5) when primary care characteristics are implemented comprehensively they lead to more appropriate care,
6) effective primary care **reduces unnecessary or inappropriate specialty care**.

TCH and UC Family Medicine partner to produce primary care physicians for Greater Cincinnati. To the extent that there are enough of these types of physicians and they practice those features of primary care that are health promoting, TCH through this partnership has enlarged its already exemplary mission to improve the health of the Greater Cincinnati community.

[1]Starfield B, Shi L, and J Macinko. Contribution of Primary Care to Health Systems and Health. **Milbank Qtrly** 2005;83(3):457-502.

3. Program Personnel: *Recruiting and Retaining the Right People*

This section introduces the key faculty in the department and the residency and provides a picture of the program's culture. The program's outcomes and value ties back directly to the people.

University of Cincinnati College of Medicine Department of Family Medicine Faculty

The Family Medicine Residency Training Program is staffed by faculty from the University of Cincinnati Department of Family Medicine. The Department has a contractual relationship with TCH to oversee and administer the FMRTP.

Dr. Jeffrey Susman is the Department Chair. The Department of Family Medicine is organized in various divisions for academic activities and each division has a director. These individuals and the respective division are noted in the table. An organizational chart is included in Appendix 3.

Division	Director
Pre-doctural Division (Medical	Barbara Tobias, MD

student activities	
Residency	Philip Diller, MD-PHD
Geriatrics	Gregg Warshaw, MD
Research	Nancy Elder, MD
Wyoming Family Medicine Center	Roy Jacobson, MD-PHD
University Pointe Family Medicine Center	Manoj Singh, MD
Forest Park Family Medicine Center	Joseph Kiesler, MD
Business Office	Stephen Roth, MBA

Each faculty member has an *academic appointment* and associated administrative and scholarly responsibilities and a *clinical appointment* with specific patient care activities. Nearly all faculty are involved in residency education with a portion of their academic time even though they have a primary academic or clinical appointment in a non-residency related activity. The GME monies from TCH sent to the Department of Family Medicine support the faculty's education activities.

TCH-UC Family Medicine Faculty

Getting the right people in the right positions is one of the essential building blocks for a strong training program. Said in another way, a program is only as strong as it faculty and supporting staff. But what makes strong faculty? The Table below lists some of the key questions about the program faculty and speaks to medical training's "hidden curriculum."

Key Questions For Evaluating Strength of Faculty: The Culture
1. Do we have effective leaders? e.g., Vision, problem framing/solving, partnering, execution
2. Do we have enthusiastic, committed teachers who connect with the learners?
3. Do we have diverse role models for trainees?
4. Do we have expertise in clinical practice across multiple settings? Hospital, Office Practice, Nursing Home
5. Do we have individuals who are passionate about matters relevant to learners?

The annual resident evaluations of the program which includes the above descriptors identify the faculty as one of the strengths of the program and would answer each of these questions in the affirmative. Strength of faculty is an important determinant of student's selection of a residency program; students seek out programs that have strong faculty. Once completing the program a few of the residents stay on or eventually return as faculty. Thus, strong faculty begets strong residents who in turn become strong clinicians and faculty.

The following provides a brief description of the faculty and each individual's respective roles and Appendix 4 includes brief biographies of the faculty including a description of their accomplishments and awards.

Faculty	Section
Philip Diller, MD-PHD*	Program Director
Joseph Kiesler, MD*	Associate Program Director, Care of Underserved, Medical Director Forest Park FMC
Montiel Rosenthal, MD*	Maternity Care/Women's Health
Chrisopher Bernheisel, MD*	Inpatient Adult Medicine Director
Lawson Wulsin, MD	Behavioral Medicine/ Family Medicine Psychiatry Program Director
Orson Austin, MD*	Geriatrics
Jeff Schlaudecker, MD*	Inpatient Medicine Hospitalist Service & Geriatrics
Jeff Morgeson, MD*	Inpatient Medicine Hospitalist Service
Douglas Smucker, MD	Global Health Director (through 1/09), Palliative Care
Robert Ellis, MD*	Conferences, Pediatrics
Reid Hartmann, MD*	UC-COM Medical Student Programs; TCHMA Family Medicine Office
Christy O'Dea, MD*	Global Health Director (after 1/09)
James O'Dea, MD*	Maternity Care/TCHMA Family Medicine Office
Jennifer Spata, MD	Maternity Care/TCHMA Family Medicine Office
Michael Holliday, MD*	Medical Director Forest Park FMC (after 1/09)
Kathleen Downey, MD*	Wyoming Family Medicine Center & Departmental Grand Rounds

To briefly highlight some of the information detailed in Appendix 4, many of the faculty have been recognized by residents, peers, local organizations, state and national professional societies for teaching, leadership, and community service. The faculty have a strong sense of social responsibility to the community and are regularly contributing to the improve the health of the community beyond their clinical practices. They represent important social capital for their supporting institutions—UC COM and TCH.

TCH-UC Residency Administrative Staff

The residency program has experienced, effective administrative staff. The Residency is supported by three very capable individuals: Sharon Mullen, Judy Flick and Renee Baird. These three administrative staff has a combined 63 years of experience within the residency program. Judy and Sharon have been with the residency program for 23 and 29 years respectively; Sharon, since the first graduating class. The compounding of experienced staff is a valuable resource for the residency and in working with TCH GME office. A brief description of their contributions is listed in Appendix 4.

TCH Specialty Staff with Significant Roles in Program Training

A training program in family medicine by its very design requires exposure and teaching by specialists. TCH is one of the few community hospitals in the nation that possesses an outstanding specialist staff, and the residents are very fortunate to work with this group of clinician-educators. Specialists who are on the TCH Medical staff and who teach in the program are listed in the table below according to specialty.

Specialty	Physician-Educator		Specialty	Physician-Educator
Cardiology	David Babbitt, MD		Pulmonary & Critical Care	Sunil Dama, MD
	Jefferson Burroughs, MD			Karthik Kanagarajan, MD
	Kevin Cochran, MD			Christopher Orabella, MD
	Charles Hattemer, MD			Christopher Schmitt, MD
	John Held, MD			Mark Scott, MD
	Richard Henthorn, MD			Padmanabha Shakkottai, MD
	Matthew Hutchins, MD		Geriatrics	Susan Davis, DO
	Thomas Jenike, MD			Arvind Modawal, MD
	Mark Kirkham, MD			Steve Mueller, MD
	Stephen Myers, MD			Mandi Sehgal, MD
	Vanshipal Puri, MD			Gregg Warshaw, MD
	Lester Suna, MD		Surgery	David Fischer, MD
	Lynne Wagoner, MD			Lisa Martin-Hawver, MD
Obstetrics/ Gynecology	Bruce Allen, MD		ENT	Thomas Kereiakes, MD
	David Schwartz, MD			Ernest Manders, MD
	Alan Schwemlein, MD			Michael Wood, MD
Vascular Surgery	Mark Harding, MD			
Neurology	Rob Neel, MD		Emergency Medicine	Sean Collins, MD
	Dolly Boughaba, MD			Gregory Fermann, MD
PM&R	Lois Deaton, MD			Liz Leennellett, MD
Nephrology	Shaoming Huang, MD			Bill Naber, MD
	Shahzad Safdar, MD			Mary Osterland, MD
ID	Bruce Hamilton, MD			Lisa Willacker, MD
	Thomas Lamarre, MD		Psych	Melvin Gale, MD

There are also many consultants from different disciplines who interface with the residents on the inpatient service. These individuals, though not listed above, also provide "real-life" education for the residents.

Nationally Recognized Aspects of the Program.

The program is nationally known for two enrichment programs. These are the Global Health/Care of Underserved Populations Track and the combined Family Medicine-Psychiatry program.

Global Health/Care of Underserved Populations Track. This special track has been offered by the program to interested residents since 1994. There are many students and residents who are interested in learning about Global Health (25-30% of all US medical students travel abroad during medical school) which often includes travel to a foreign country to deliver health care to needy, impoverished communities. The UC Department of Family Medicine has sponsored travel experiences for residents and faculty to the country of Honduras in Central America first beginning in 1990. This experience was started by Dr. Jeffery Heck who founded a non-profit organization named Shoulder-to-Shoulder in 1993. A key element of Shoulder-to-Shoulder is a continuous partnership with the same poor rural community that has clear need for health care. Shoulder-to-Shoulder has two missions one educational and the other clinical. The residency has been heavily involved in the educational mission and has assisted with the clinical care in the remote village of Santa Lucia, located in the state of Intibuca in Honduras. A permanent clinic site has now been in operation for over 15 years and the residency offers a two week multi-disciplinary course at TCH followed by a two week field experience in Honduras. Students from the UC COM, nurses and nursing students from UH and TCH also participate.

This resident enrichment experiences offers a much broader knowledge and experience for understanding the health of a community. Faculty are members of the national organization, Global Health Education Consortium (GHEC), and the program faculty and residents have been in leadership roles with GHEC and its board. Faculty have also published in this area. Faculty have also been involved in the AAFP International Division's annual meetings on teaching global health, and at the National Family Medicine Resident and Student annual conference. It is through such participation at a national level that the program has gained national recognition and this translates into a niche for resident recruitment. Over half the students who interview in the program do so because of this enrichment program. Half the students who match in the program participate in the track and take trips abroad to study global health problems; in the past 15 years residents have traveled to 38 different countries. Many residents recognize this as a clear strength of the program and often go on to work in underserved communities in the US. Five graduates in the past 15 years are working fulltime in other countries.

Aside from the contributions made to the communities where the TCH-UC residents and faculty go, a hidden value of this enrichment experience is how it helps select/attract residents with specific desirable character qualities—residents who are very bright, community oriented, broad-minded, self-less, flexible team players that create a dynamic resident culture. The program has helped get the "right people on the bus."

Combined Program in Psychiatry-Family Medicine. This is a five year program that leads to a graduate being board eligible in both Family Medicine and Psychiatry. Our program is one of 8 nationally and is considered one of the strongest because of its balance in both departments. The Psychiatry program at UC is known for its work in psychopharmacology while continuing the tradition of a full psychotherapy year. The family medicine program is considered an excellent complement for broad based training in primary care with the strengths already mentioned. We draw from across the nation from a small number of committed students who desire to integrate these two specialties.

B. Program Educational Outcomes (Grades--self-evaluation)

1. ACGME RRC Accreditation (Grade B)

The longest length of time for granted by the ACGME is 5 years. The last RRC review the program got a 4 year accreditation. Prior to the move to TCH the program received the longest allowed for the previous two cycles. With the multiple changes that occurred with the move to TCH the program is still seeking the full five year accreditation at the next review.

Year of ACGME Site Visit	Institution	Length of ACGME Accreditation	Citations (#)
1997	Mercy Mt. Airy	5	3
2004	TCH	3	13
2007	TCH	4	14

The goal is to get a five year accreditation cycle with <3 minor citations.

2. Program Recruitment Performance (Grade D)

One of the measures of a successful program is filling through the match, and more specifically, is how far down on the match list the program needs to go to fill the slots; filling primarily through the top slots is an indication that the program has done very well in getting the best people available. In addition, another good indicator of recruitment success is how many strong students from the University of Cincinnati entering family medicine also choose to stay in Cincinnati and match with The Christ Hospital-UC Program.

Since moving to TCH the program has filled through the match only 2 out of 6 years. The historical experience for the program for the last 10 match years is shown in the table below:

Year	Number Offered in the Match	Number filled In match	How far down/total ranked	# UC students matched	# of US Seniors Matching in Family Medicine
1999	10	10	53/71	2	2015
2000	10	10	21/64	5	1817
2001	10	9	57/57	5	1501
2002	10	9	48/54	4	1399
2003	6	5		3	1226
2004	4	2	15/30	0	1185
2005	4	4	19/19	0	1117
2006	4	4	10/34	2	1123
2007	6	2	31/34	0	1096
2008	6	3	14/45	2	1156

In white = Mt. Airy years; 2003 was the year when the match and recruitment occurred at Mt. Airy knowing that the program would close at Mt. Airy and be moving when the new residents arrived; In gray = TCH match years;

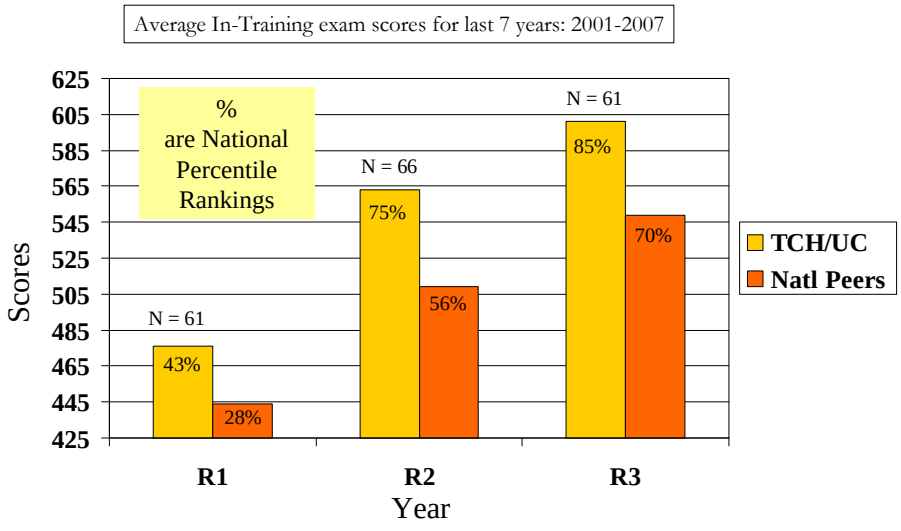
Our recent match experience is best understood in a larger context for students entering primary care. US Medical student interest in family medicine has declined by nearly half over the last 10 years: from 2015 in 1999 to 1156 in 2008. Thus, the time when the program went through its major move to TCH from Mt. Airy was when the competition for US Medical students was increasingly more intense with a 50% reduction in US Seniors choosing family medicine. Not surprisingly, with the move to TCH from Mt. Airy local rumors about the program's demise, or temporary placement at TCH, financially instability, or lack of support from the system enveloped the program in the early years of the move. This also contributed to challenges of filling through the match.

What has also been noticeable in the first five years is that the strong students from UC who were interested in Family Medicine ended up leaving the state or matching with a different regional program; for the first time in the history of the program no UC student matched in the program in 2004 and 2005, and then again in none matched 2007. Thus, the first five years have posed significant challenges for the recruitment to the program due all to the programmatic changes that occurred.

Many of the early concerns have been addressed and in the last three classes we have once again been successful recruiting students from UC COM (in 2007 we brought in another UC student in the first half of the year from another program). However, more work needs to be done to return to the experience of regularly filling through the match with consistently high quality candidates. A number of key pieces are in place, but the primary program problem identified by recruits, current residents, and faculty is the Forest Park Family Medicine Center. This office is small, under-resourced and is a considerable distance from TCH.

3. In-Training Examination Scores of Trainees (Grade A)

Every fall family medicine residency training programs administer an in-training examination. This is a test of medical knowledge for the broad discipline of family medicine. The chart below shows the results of the average in-training examination scores from the past 7 years.



What is notable is that: 1) for each training year the residents in the program score well above their peer group, 2) that each year there is an increase in score and 3) by the third year – the residents are scoring *at the 85% overall.* This indicates that the program educational environment helps produced strong residents by the time they graduate even if they start with an average or below average medical knowledge base. This is a credit to the residents who have a great work ethic and sense of professionalism, to the faculty who are excellent teachers, and to the program structure that includes rotations through some of the best hospitals for adult, pediatrics, and obstetrics training. For eight of the last nine years the highest sub-section scores have been for Behavioral Science. This is a by product of having the combined program in Psychiatry-Family Medicine.

4. ABFM Passing Rates (Grade A)

Board Certification in Family Medicine requires successful completion of an accredited family medicine residency training program and passing the certification test offered by the American Board of Family Medicine. It is customary for nearly every graduate of our program to take this test. With the combined program in Family Medicine-Psychiatry we have had graduates who have chosen not to pursue a career in family medicine, but rather psychiatry. Some of these graduates have decided not to pursue Board Certification in Family Medicine.

The *passing rate is 100%* for all family medicine residents and for those family medicine-psychiatry residents who have chosen to practice both family medicine and psychiatry.

5. Program Evaluation by Trainees & Faculty (Grade B+)

Every year the program is evaluated internally by the residents and the faculty. The process includes a general survey of the program, evaluations of each rotation, and assessment of faculty performance. This is a marker of satisfaction and performance that informs us of

General Rotation Survey Summary 2007-2008

Program Strengths & Weakness on scale 1 weak to 10 excellent

Program Strengths*		Program Weaknesses* (< 5.0)	
Residency Program Leadership	8.46/10	Forest Park FMC	4.4/10
TCH	8.30/10	Convenience	4.5/10
Faculty Strength	8.06/10		
IH Program	8.06/10		
Resident Cohesiveness/support	7.93/10		
Patient Population	7.86/10		

Program Rotation Ratings on a scale of 1 to 6

Ratings of Family Medicine Directed Rotations		Ratings of Sub-specialty Rotations	
Adult Inpatient	5.35/6	Peds ER	5.25/6
IH/Underserved	5.09/6	UH ER	5.14/6
FMC	4.5/6	Peds IP	5.14/6
Geriatrics/Elderly Care	4.25/6	Newborn	4.6/6
Electives	4.15/6	Ortho	4.57/6
Behavioral Science	4.08/6	Ambulatory Peds	4.5/6
Conference Series	4.07/6	Critical Care	4.45/6
OB TCH	3.9/6	Urology	4.4/6
Scholarly Opportunities	3.66/6	Dermatology	4.3/6
Health Systems Management	2.63/6	Opthalmology	4.16/6
		ENT	4.0/6
		General Surg II	3.85/6
		Sports Medicine	3.8/6
		OB GSH	3.8/6
		General Surg I	3.66/6
		Cardiology	3.5/6
		Gynecology	2.4/6

how well the program is doing from the learner's perspective and is used to guide program improvement. This review of the program reveals current strengths and weaknesses.

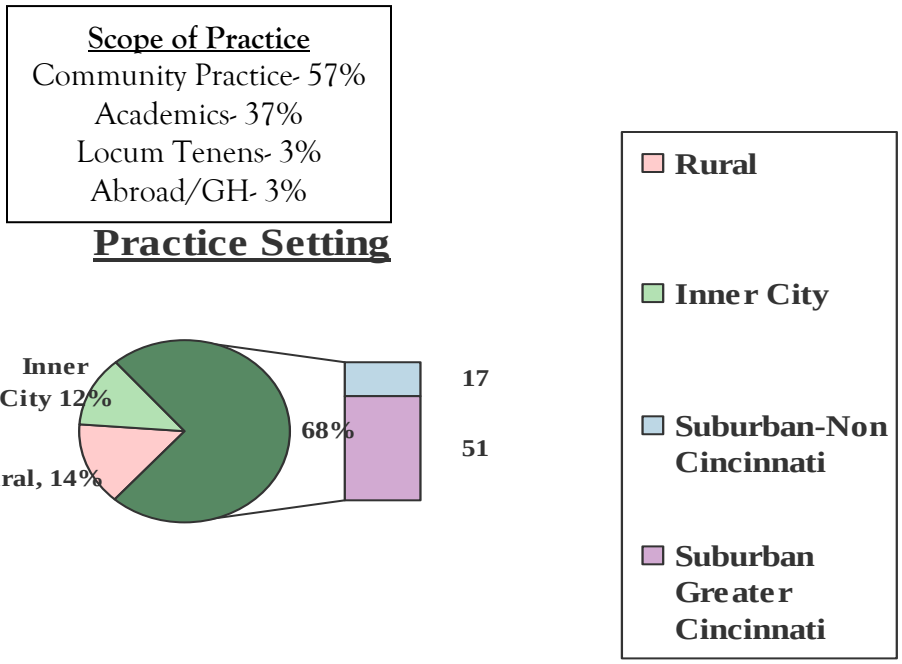
Strengths include program leadership, the hospital, the faculty, and the international health program. From a rotation standpoint the highest rated rotations are the Family Medicine inpatient service at TCH, the emergency medicine experience at Children's Hospital and University Hospital and the International Health experiences. Chief weaknesses include the Forest Park FMC and the convenience for learning in the program.

6. Graduate Outcomes: TCH Primary Care Pipeline and Beyond (Grade A)

The primary purpose of the program is to place family physicians in communities that need primary care. Communities of need can be described as health shortage areas. Ohio and specifically Greater Cincinnati have such areas. The Family Medicine residency training program has placed a number of physicians in such areas.

A important companion goal is to train physicians who will stay in Greater Cincinnati, become familiar with the workings of TCH, and choose TCH as their primary hospital for their patients. This is an important benefit of sponsoring residency programs by the institution.

The program provides a broad set of learning experiences that meets the varied needs of the resident career paths. The residents are competent and well trained for these varied roles. In addition, the residency program graduates can also be characterized by what they end up doing also: family practice in a urban setting, an inner city setting, a rural setting, fellowship training, and academic medicine. In the last 5 years (2004 through 2008) there have been 30 Family Medicine graduates and 7 Family Medicine-Psychiatry graduates. Of these about half stay in Greater Cincinnati and of these eight have joined the TCH/UC program.



C. Value to The Christ Hospital

This section highlights the financial and social metrics often used to assess the value of a Family Medicine Residency Training programs to a hospital.

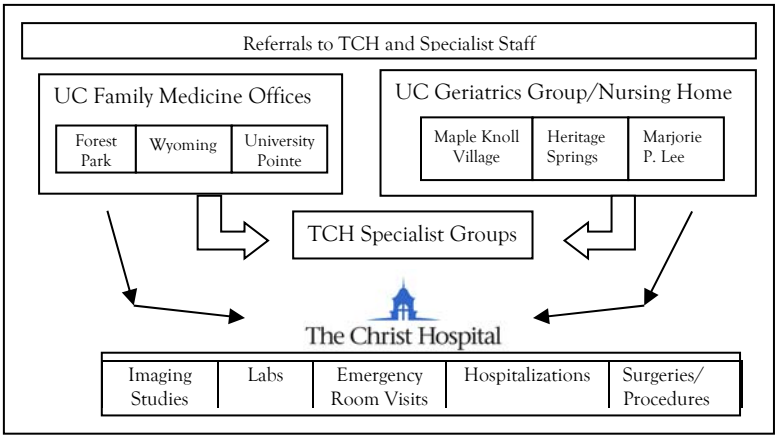
Family Medicine is not so much a business as a social good whose value is not in generating large profit margins but instead contributes to a community benefit relative to a social mission, not measured in financial returns. Financial goals are important and necessary but often secondary. The proper framework to measure contribution must also include an assessment of how effectively the group delivers on the social mission and makes a distinctive impact, relative to the resources required to sustain or maintain the group. Thus, two ways the value of Family Medicine is assessed include: 1) Social (e.g., community benefit/impact) and 2) Financial (e.g., contribution margin).

The value of a Family Medicine training program to a sponsoring institution derives from patient referrals and inpatient volume, community benefit of the program services, a pipeline for primary care physician recruitment, human capital resource for hospital leadership and committees, creating opportunities for institutional partnerships, promoting the name of The Christ Hospital at a regional and national level, and extending the hospital mission of primary care in the community.

1. Hospital & Specialists Referrals: Multiplier Effect and Downstream Revenue (Financial)

Referrals are part of coordinating patient care and can be categorized from a hospital based test or service (labs, imaging studies, diabetes education), an encounter in the emergency room, a hospitalization, or a referral to a specialist in his office who then may choose to utilize the hospital. Tracking such referrals at the hospital level requires an accurate method to identify a patient's primary care physician which is still being developed for the new IT system at TCH. Even though no method exists for an accurate assessment other surrogate methodologies are available to estimate the downstream revenue.

The Family Medicine Department of the University of Cincinnati College of Medicine has multiple ambulatory settings that generate hospital activity: 3 Family Medicine offices (Wyoming, Forest Park, and University Pointe), the prenatal clinicand multiple nursing homes (Maple Knoll Village, Heritage Springs and Marjorie P. Lee). *This activity has been studied and has two important dimensions to capture: 1) the multiplier effect and 2) downstream revenue.*



The "*multiplier effect*" is ratio of the amount of money charged by the hospital for patients that use a given primary care office to each dollar charged for work done in the ambulatory office. Every reported study has demonstrated that the multiplier effect is real and significant ranging from 6[1,2]-10[3] (full family practice population) to 17[4] (geriatric population). Related to this term is the *downstream revenue* which is the total amount of hospital dollars collected from patients that originate from a specific primary care office in a set period of time.

Using estimates of the known multiplier and the amount of dollars charged in the ambulatory setting we can generate a range of possible impact on the downstream revenue for TCH and specialists as a result of the relationship with UC Family Medicine for both the FMCs and the Geriatric clinical sites. (At the end of five years we do not have clear accounting of the multiplier effect or the downstream revenue generated by patients who originate from the UC Family Medicine clinical site for TCHs. Initially some leakage occurred in the early start-up years, but as new relationships have solidified patients are using TCH as a preferred hospital more in the fifth year than in the 1st year.) What is not included in the table is the revenue associated with the MOB Prenatal clinic and the new TCHMA office is too new to be included.

Office	Gross Charges Actual FY08	Multiplier Used	Net Multiplier Effect $$ to TCH (HIGH)	Net Multiplier With 50% Leakage (LOW)
Forest Park FMC	$1,392,194	6	$8,353,164	$4,176,582
Wyoming FMC	$2,781,856	6	$16,691,136	$8,345,568
University Pointe	$696,657	6	$4,179,942	$2,089,971
Geriatrics	$527,963	17	$8,975,371	$4,487,686
TOTAL	$4,667,392	-	$38,199,613	$19,099,807

[1]R Schneewiess, K Ellsbury, G hart, JP Geyman. The Economic Impact and Multiplier Effect of a Family Practice Clinic on an Academic Medical Center. **JAMA** 1989;262:370-375.

[2]JW Saultz, G McCarty, B Cox, D Labby, R Williams, S Fields. Indirect Institutional Revenue Generated from an Academic Primary Care Clinical Network. **Fam Med** 2001;33(9):668-71.

[3]E Woodcock. Primary Care in the Academic Setting: Understanding the difference between the private sector and quantifying the multiple effects to the Institution. **Med Group Manag J.** 1999;46:15-22.

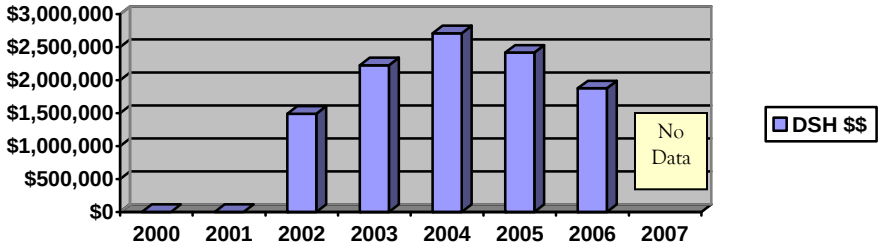
[4] S Dang, G Baker, DA Lipschitz. Financial Effect of a Hospital Outpatient Senior Clinic on an Academic Medical Center. **J Am Geritr Soc** 2002;50:1621-28.

2. Disproportionate Share Dollars to TCH (Financial and Social)

The United States government through the medicare program provides special funding to hospitals who treat significant populations of indigent patients through the Disproportionate Share Hospital (DSH) Program. To qualify for the DSH payment adjustments a hospital must reach a threshold of "bed days" as a percentage of total bed days that are due to patients who have Medicare SSI and Medicaid, Non-Medicare. The chart below shows that TCH did not qualify for DSH monies in the 2000 and 2001 years, but did in the following years. The program began sending inpatients to TCH in 2003 and the hospital

has consistently qualified for DSH monies every year the program has been at the hospital and in higher amounts than in the first qualifying year. Both the Forest Park office and the Prenatal clinic take Medicaid patients. It is not entirely clear that the hospital's consistent qualifying and higher payments are due directly to patients originating from the Family Medicine Residency program, but it is recognized in other institutions in the US that the Family Medicine Centers typically have a high percentage of patients who are Medicaid eligible and considered indigent and do influence the DHS payments to its parent hospital.

Disproportionate Share Hospital $$ to TCH 2000 to 2006



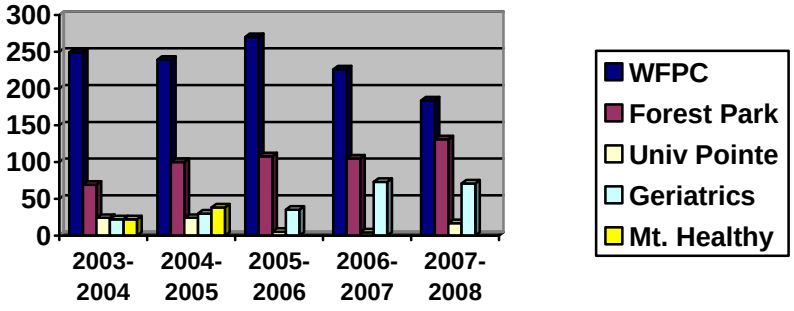
Data from: http://www.cms.hhs.gov/CostReports/02_HospitalCostReport.asp#TopOfPage

3. Family Medicine Hospitalist Service at TCH (Financial and Social)

The hospitalist service for family physicians is a teaching service and is staffed by faculty in the Department of Family Medicine. This is one of two hospitalist services at TCH—the other being run by the Mt. Auburn Hospitalist group. The first Family Medicine inpatient director was Dr. Jeffrey Heck who moved to Asheville, NC in 2004. Dr. Diller served as interim director in the second year and since then Dr. Christopher Bernheisel has been the director of this service. He is currently supported by Dr. Jeff Schlaudecker, Dr. Jeff Morgeson, Dr. Phil Diller, Dr. Leila Saxena, Dr. Jennifer White, and Dr Montiel Rosenthal who also rotate as attendings on the service.

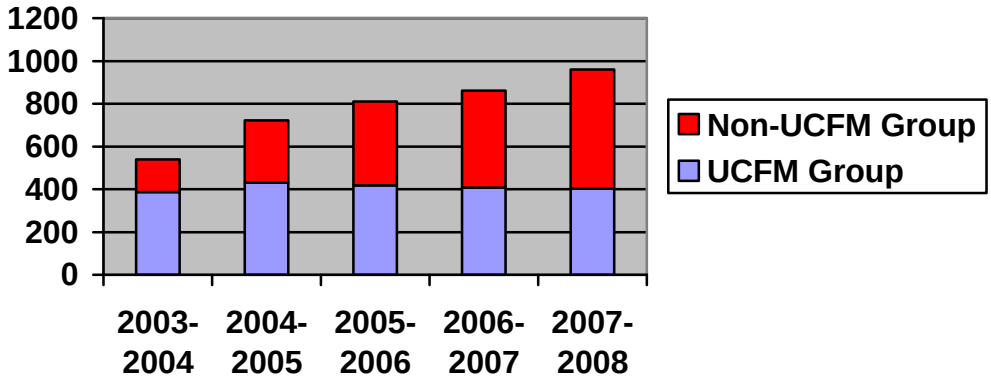
This service admits patients from any family physician in the Greater Cincinnati community to TCH. In the early years the majority of patients originated from one of the five Departmental offices/sites with the largest office, Wyoming, contributing the most. Over the past five years we have seen the expected increase in patients originating from Forest Park and from the Geriatric sites with fewer patients originating from Wyoming (see next graph below).

Admissions to Family Medicine Inpatient Service
From UCFM Group Sources



The near doubling of growth of admissions to inpatient service for the last 5 years from a beginning of 540 to a recent high of 961 is shown in the graph below. Most of the growth represents admissions from FPs (Non-UCFM Group in red) not affiliated with the UC offices. Somewhat unexpectedly, by year five community FPs not associated with the department offices now admit more patients to the service than the departmental offices. A number of community FPs have requested our group provide care and coordinate the needed care with our specialists colleagues. Our specialist colleagues have also asked us to provide care for their unattached patients and we are able to do that as well and those patients are included in the Non-UCFM group as well. *The physicians on the service have developed strong relationships with the community physicians. This is important for the future since more and more FPs who chose not to do hospital work and utilize hospitalists to care for their patients. This 2nd hospitalist service represents value back to TCH through the ongoing relationships our physicians have with community FPs. However, it also presents a challenge to coordinating care and this care coordination is an important area of medicine for the future.*

Annual # of Admissions to the Family Medicine Hospitalist Service at TCH (all sources)



The Family Medicine inpatient service has a reputation for high quality of care, short lengths of stay, high patient satisfaction, and innovation. Family Centered Rounds, where the whole team meets with the family and the patient at the bedside are on a daily basis, and this is one of the innovations in care brought to TCH inpatient medicine. This facilitates communication of the diagnosis, testing and care plans with the patient and the family.

4. Prenatal and Obstetric Care at TCH (Social—community benefit)

Family Medicine training programs are required to have family physicians who do Obstetrics on the faculty and are also required to have sufficient volume of delivery experience for accreditation. About 15% of family physicians include OB as part of their scope of practice; in our program over the past 5 years 25% are doing OB after graduation. Most family physicians who are doing this practice in rural or inner city America. Though there is considerable debate about the place for OB in family medicine—the need for family physicians who do obstetrics continues at a national level. Here in Greater Cincinnati it is not surprising

with the large number of OB-GYN physicians and groups and the hospital cultures that few family physicians are doing obstetrics; yet this remains a program requirement.

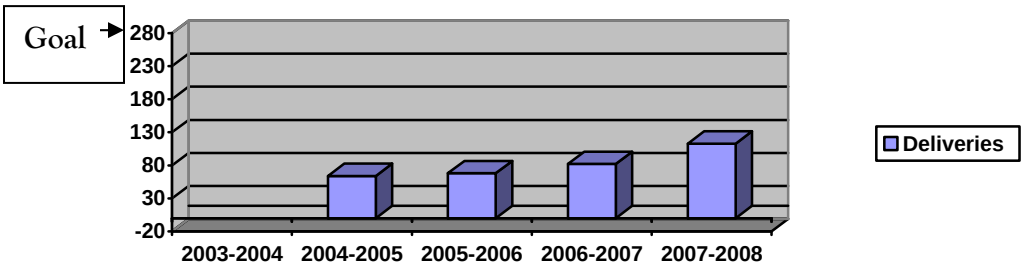
The OB section of the residency is led by Dr. Montiel Rosenthal with supporting faculty including Michelle Zamudio CNM, Elizabeth Lazaron MD, James O'Dea MD, and beginning in January 2009, Jennifer Spata, MD. Obstetrical back-up is also required and in the first year the Mt. Auburn OB-Gyn Associates served as our back-up, and since the second year our back-ups have included Dr. Bruce Allen, Dr. David Schwartz, and Dr. Israel Washington. The Family Medicine approach to prenatal care, labor and delivery is low risk with intervention less often used; first time c-section rates are generally lower about 21%.

Due to the limited number of deliveries available for resident training at TCH, the program has had to look outside the institution for a setting where sufficient delivery volume is assured. In 2005 the program gained approval to have residents train in OB at Good Samaritan Hospital. This has been a good experience and in general, the number of deliveries is adequate. However, the goal is to have all the training experience for OB at TCH, and for this to happen, we project a need of 250-300 deliveries to originate from our offices; this would increase the number of deliveries at TCH by 8% and would be a new source of patients to labor and delivery for the hospital. Alternatively, working closely with a few OB-GYNs at TCH who are interested in residency training and willing to share their practice would also make it possible to have all the training at TCH.

To grow the number of deliveries for the program TCH administration has supported the Prenatal clinic in the MOB. The Prenatal clinic opened in April 2006 beginning with 2 ½ days and continued growth created the need for a 3rd ½ day. *The prenatal clinic contributes to the TCH's community benefit. Patients who attend this clinic initially do not have any insurance and are self-pay; eventually 90% of the patients enroll in Medicaid.* This clinic has been featured as part of the hospital's marketing of community outreach with notices in the *Cincinnati Enquirer*.

The figure below shows the increase in OB volume at TCH for the Residency Training Program over the first five years of the program. The prenatal clinic has become a significant source of deliveries for the OB program. OB patients also originate from the Forest Park FMC. This has slowly increased over the past five years. Despite this growth we are still short of the targeted number of deliveries needed 5 years after being at TCH.

Deliveries at TCH Originating from Family Medicine Offices



5. Family Medicine Physician Recruitment to the Medical Staff of TCH or Placement in the Greater Cincinnati Area. (Social)

Recruiting and retaining primary care physicians to Cincinnati and more specifically those who use TCH is an important program goal in the next decade. The Department of Family Medicine presently functions as the recruiting face for Family Physicians at TCH. *Recruitment of Family Medicine Faculty.* However, what is often overlooked is that when TCH partnered with the UC Department of Family Medicine in 2003, 22 faculty physicians began to send their patients to TCH moving a large portion of hospital work from other hospitals. The cost of this new relationship was primarily secured through the GME dollars through CMS mechanisms and required little investment by TCH. No recruitment dollars were required for beginning this relationship, and no monies were needed to purchase practices.

Because of its academic opportunities the Department is able to attract Family Physicians who desire to include academic work as part of their career. An example of this is the recruitment of physicians for the new TCHMA Family Medicine office that opened in MOB in November. Three new family physicians will start this office and represents the first phase of a plan to move the training of residents from the Forest Park site to a site near or on TCH campus. These three physicians would not have considered TCHMA without an academic linkage to the UC Department of Family Medicine. Financial support from TCH has helped in recruiting these three physicians and the office is a TCHMA office.

Residency Pipeline for Family Medicine Physicians. When TCH agreed to sponsor the Family Medicine Training Program TCH secured and expanded a built-in pipeline for growing its primary care network. It is well known that a significant percentage of graduates of residency training programs choose to practice in the area where they train and stay connected to their parent hospital. The residency training program continues to seed physicians in the greater Cincinnati area. The table below shows the outcome of graduates from the program since moving to TCH.

Graduates who trained at TCH who:	#	%
Joined the Department of Family Medicine in Cinti	8	21
Located in Greater Cincinnati, not w/ DFM	10	27
Who located in Ohio outside Greater Cincinnati	5	14
Who located outside the Ohio and the region	14	38
Total	37	100%

Recruitment of primary care physicians through partnership with the TCH-UC Residency training program is a very cost-effective method for growing the primary care staff of TCH. A strong training program attracts strong medical students—some of whom will join the department or future TCHMA offices with minimal "recruitment" dollars from TCH Physician recruitment. Thus, in this way TCH Physician recruitment resources can be directed to other target needs for the hospital. Further, little orientation and training is necessary for residency graduates to begin practice and utilize hospital specialists, testing and imaging services.

A Future Opportunity. Eighteen physicians have graduated in the first five years and work in Greater Cincinnati; ***10 of the graduates are working in offices that do not necessarily***

relate to TCH. This is not surprising since TCHMA was created in 2008 and no offices other than the Department of Family Medicine offices were recruiting Family Physicians that utilize TCH. ***Having Family Medicine offices that could receive graduates that were not interested in an academic component represents a future opportunity for TCHMA and the hospital's physician recruitment plans.***

6. Involvement in Hospital Leadership & Committees (Social)

The program faculty represent significant human capital and are an asset that can be recruited for participation on hospital committees and leadership roles in the institution. Many of the faculty have gone through leadership training and/or developing high performance teams. A number of faculty are leaders in their field on a regional and some on a national level. The table below includes the current faculty members and their involvement on hospital committees.

Individual	TCH Committee
Chris Bernheisel	CCCC
Phil Diller	MEC, PIC, GME, Department of Family Medicine, Sentinel Events, GME sub-committee
Montiel Rosenthal	OB-GYN, Family Care
Jeff Schlaudecker	Family Centered Care Committee
Gregg Warshaw	GME
Judy Flick	GME

With the increased growth of family physicians on the medical staff, the MEC and the Board of Trustees approved a new Department of Family Medicine. This fledgling department can be a vehicle to reach out to community family physicians through CME activities and future growth initiatives that the hospital chooses to promote.

7. Recognition for The Christ Hospital through Accomplishments of Program Personnel (Social)

TCH-UC Family Medicine Residency training program has a strong faculty as evidenced by the number of awards and strength of the program evaluations by the residents and students. This track record of accomplishments and visibility strengthens the reputation of TCH in the community, around the state, and nationally. When a faculty member receives an award or presents at regional or national meetings this promotes the TCH's name and the University of Cincinnati. The table in Appendix 4 highlights selectively some of the awards and presentations that have accrued to faculty and staff in the past five years. These awards also speak to the human capital resource that is an asset for TCH.

8. Institutional Partnerships (Social)

To succeed in health care requires strong partnerships. The UC Department of Family Medicine requires partners to accomplish its mission of education, patient care, and scholarly activity. Few Family Medicine Departments in the US exist independent of a hospital, medical school or large primary care group. The Department's success is predicated on partnerships at TCH and other institutions in the community. Partnerships are built around faculty with expertise, common interests and mutual goals. Such partnerships by the Department can be an asset for TCH too.

This relationship between the Department and TCH has grown in the first five years to be mutually beneficial to both entities. The Department's Cincinnati residency program is sponsored and strongly supported by one of the premier community hospital's in the United States. In return, TCH by sponsoring and partnering with the Department has created a more diverse primary care base that includes one of the largest groups of family physicians in the city. Though currently members of Alliance Primary Care (APC) these physicians are permitted under contract to admit their patients to TCH and this is the preferred hospital for the Department; TCH is the only hospital where the Department staffs and rounds on adult patients. TCH has seen a growth in the number of patients admitted by community Family Physicians. This partnership is an example of how the University can extend itself to TCH and how TCH can promote and extend its mission in the community. In addition, this is an example of how APC, the Department, TCH and COM are working together to promote primary care development in the region.

The Residency/Department of Family Medicine also has ties to other community institutions. These are listed in the table below.

Partner	Type of Partnerships
Maple Knoll Village	Geriatrics care, education
UC-COM/UC Physicians	Medical student education, Research, CME
Alliance Primary Care	Education, Clinical care, community benefit
TCHMA/Prenatal Clinic	Education, Clinical care, community benefit
Respite Center	Clinical care homeless
Neighborhood Health Center	Clinical care indigent
Homeless Van	Clinical care homeless
Greater Cincinnati Health Collaborative	Improving Quality in offices; Patient Centered Medical Home
Crossroad Health Center	Clinical care inner city population
Cincinnati Children's Hospital	Clinical care, ADHD quality collaborative, Education
Good Samaritan Hospital	Women's Care education
University Hospital	Emergency Medicine Care, Mental Health Care & Education
Veteran's Hospital	Dermatology education

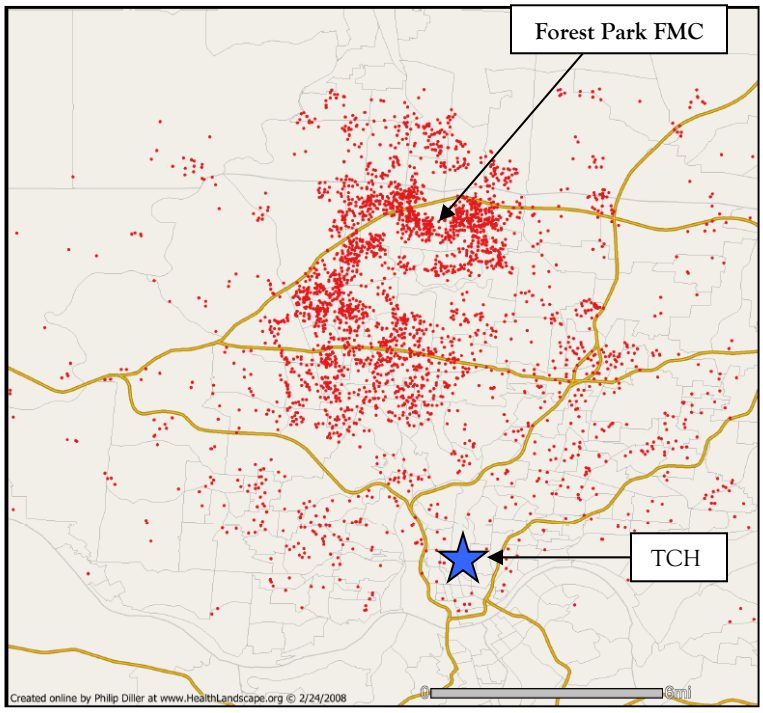
Nursing Home Practices	Geriatric clinical care
Greater Cincinnati Health Foundation	HealthLandscape, data support for community health; residency practice reports
Vitas Hospice Care	Hospice/Palliative Care
Drop-in Center	Indigent Care/homeless care
Race Track Clinic	Indigent Care

9. Extending the Mission of TCH Outside the Hospital (Social & Financial)

One of the missions of The Christ Hospital is to promote the health and well being of the greater Cincinnati Community. This is primarily done through the excellent services provided at the Hospital and through the various charitable activities the hospital supports. *With the support of the Family Medicine residency program, the hospital has extended its benefit into the community even further.* The residency ambulatory office and its related Family Medicine Department offices and extensions touch the community as an outreach that has not been included as part of the TCH mission prior to the FM residency program.

The Forest Park office has an active patient file of 7800 patients. The map of Hamilton County with major highways and zip code areas below reveals where patients live who use Forest Park as their source of primary care. Increasingly, over the first five years more and more patients recognize TCH as the preferred hospital.

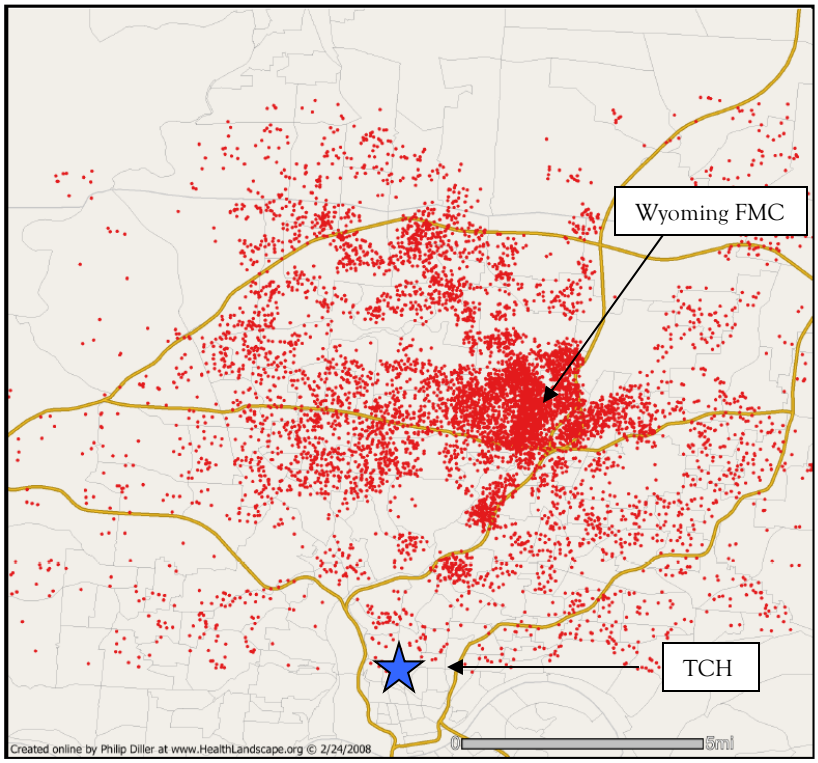
2006 Forest Park Patients Central Hamilton County View



Legend:
Fam Med 2006 -- FMyear
2006—2006

Wyoming Family Medicine Center is an older and more established practice with over 20,000 active patients. The patients and communities served by this office are shown on the map below.

2006 Wyoming FMC Patients



Legend:
Fam Med 2006 -- FMyear
2006—2006

Maple Knoll Village which is the base for the Geriatrics Fellowship sponsored by TCH; TCH also is the preferred site for inpatient admissions.

The maps above demonstrating the location of individual patients give a visual representation of how the partnership with the UC Department of Family Medicine and its training programs for Family Medicine residents and Geriatric fellows has extended TCH's mission of improving the Greater Cincinnati community's health out into the community.

D. Program Costs to The Christ Hospital: *Direct, Shared, and Saved*

This section includes a discussion of the revenues and expenses associated with the FMRTP and reveals that the hospital has profited on the program considering only the GME funds flow associated with the program.

1. Total GME Revenues and % Medicare Bed Days at TCH: *Larger Program Context*

Medicare provides additional payments to inpatient DRGs in teaching hospitals as a result of the extra cost of patient care associated with a teaching service (Indirect Medical Education-IME payments). This latter assumption is hotly debated but for now, this is the methodology applied and hospitals receive this additional payment based on a complex formula that is largely driven by the percent of bed days that are due to medicare patients. In addition, Medicare provides a smaller payment for Graduate Direct Medical Education Expenses (GME, GDME or DME) to cover resident salary and benefits. The table below shows the amounts the hospital has received from 2000 to 2006 (2007 year has not been reported yet)

Year	IME	GME A	GME B	**Total**	% Medicare Bed Days
2000	$6,457,319	$1,962,903	$407,269	**$8,827,491**	37.6%
2001	$7,006,184	$1,994,794	$429,017	**$9,429,995**	40.3%
2002	$5,528,481	$1,893,337	$396,319	**$7,818,137**	42.8%
2003	$7,748,282	$2,616,068	$551,387	**$10,915,737**	43.0%
2004	$8,168,194	$2,384,666	$523,971	**$11,076,831**	45.1%
2005	$7,598,756	$2,292,433	$490,977	**$10,382,166**	45.8%
2006	$6,803,863	$2,416,320	$560,314	**$9,780,504**	43.9%
2007	Not Filed Yet				

Gray shaded years are when the Family Medicine Residency has been at TCH. Data are downloaded from: http://www.cms.hhs.gov/CostReports/02_HospitalCostReport.asp#TopOfPage

The Christ Hospital has a resident FTE cap of 67.77, and annually receives on average ***$10,538, 810*** (the last 4 cost report years, 2003 to 2006) for Graduate Medical education activity through CMS payments. Because of the generous reimbursement for GME the hospital likely makes a profit on GME activity for its ~68 FTEs.

2. Revenues and Costs to TCH for the Family Medicine Residency Program: *Calculating the Contribution Margin*

The total cost of the Family Medicine residency program to TCH is about *$2,350,140* annually (Resident Salaries and Fringe Benefits = $957,239, and Residency Program Administration = $1,392,900). In FY09 TCH is estimated to receive *$2,781,254* from CMS for GME activity due to the Family Medicine Residency Program (16.77 Resident FTEs; projected payment of $116,856 IME/FTE and $48,991 DME/FTE; Mike Gramalgia supplied the $$ estimates per FTE for TCH for FY09). Thus, the **contribution margin** on direct

revenues and expenses without considering any other clinical revenues or costs saved is an estimated positive **$431,111**.

The cost of the Family Medicine Residency Training Program can be broken down into different categories—some of these costs are shared with the Department of Family Medicine and some with Alliance Primary Care. Thus, no one entity bears the total program costs with each entity gaining some benefit.

The chart below indicates the expense for each category related to the residency and the amount that is borne by the different partners.

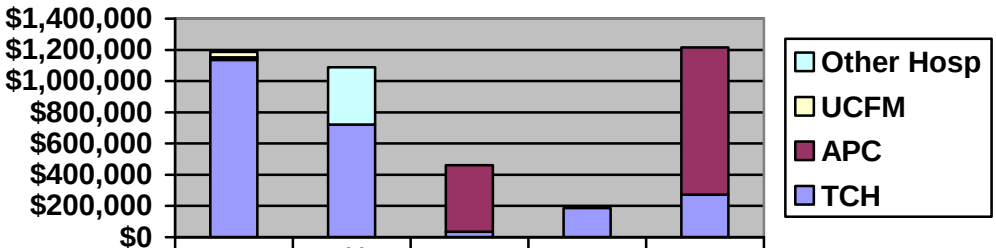
Residency Administrative Costs: including faculty academic salaries, rent, recruitment, Global Health Track

Resident Salaries: includes fringe benefits, based on where the residents do their rotations (Based on the FY05 costs—awaiting the FY08 salary & Fringes). Residents are TCH employees and no money comes to the program for direct resident salary and benefits.

Inpatient Service: this is the Family Medicine Hospitalist Service, under APC contract

Obstetrics Services and Prenatal Clinic in the MOB

Family Medicine Center at Forest Park: this is an APC office with shared costs

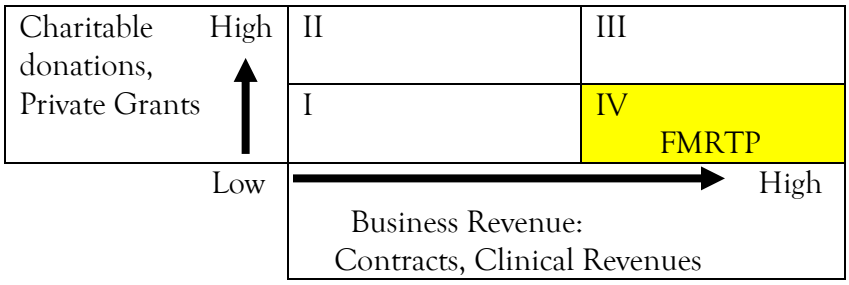


	Res Admin	Resident Salary &	Inpatient	OB	FMC
Other Hosp	$0	$366,380	$0	$0	$0
UCFM	$35,890	$0	$0	$0	$0
APC	$16,232	$0	$425,529	$0	$941,895
TCH	$1,134,951	$721,624	$34,972	$185,829	$272,764

Note: TCH Contribution to FMC is due to some resident salary & FB coverage (~$235,615 in FY09) and from some of the Residency Qtrly payment ($37,149 in FY09)

Resident salaries are covered from GME dollars from the various institutions where the resident rotations occur. Thus, contributions come from University Hospital, Cincinnati Children's Hospital and Medical Center, the Veteran's Hospital and TCH. TCH is responsible for about 71% of the Family Medicine Resident salaries and fringe benefits.

Another way to look at the cost of the program to TCH is to define where the program gets it monies compared to other non-profit entities that are part of the social sector[1].



The department revenue sources are predominately based on contract revenues (TCH GME revenues, and GME revenues from other hospitals) and clinical revenues (APC clinical revenues). There have been a few private grants that have contributed some revenue, and there is no endowment or charitable sources that contribute to the residency's work.

[1] **Jim Collins. Good to Great and the Social Sectors: A Monograph to Accompany Good to Great** HarperCollins; 2005.

3. Cost Savings to TCH

Physician Recruitment. One of the costs that hospitals typically incur is in physician recruitment—anywhere from $50K-$100K per physician. During the first five years, there have been 7 TCH graduates who have joined the program. These physicians were recruited by the Department of Family Medicine and did not cost TCH any monies from its recruitment budget—thus saving the hospital $350-700,000 dollars in the first five years. These physicians will also use TCH as their primary hospital and contribute to the hospital's future downstream revenue.

Family Medicine Teaching Service as a Hospitalist Service for Community Family Physicians. In 2005-2006 the average subsidy for a hospitalist per FTE was $60,000; in the 2008 survey by the Society of Hospital Medicine, the average subsidy increased to $100,000.[1] The Family Medicine Hospitalist service is paid for through clinical revenues and GME revenues that flow to the residency program for the teaching activity. This arrangement has saved the hospital costs since the service does not require additional hospital monies to subsidize the faculty salaries for doing inpatient medicine. There are 2.5 FTEs on the inpatient service and this represents a potential savings of $137,500-$250,000 annually.

[1]http://www.todayshospitalist.com/index.php?b=read_blogs&cnt=10022

Summary of Costs to TCH.

Considering the direct costs and the costs the program saves the hospital on an annual basis, *the financial margin is strongly positive and this is without considering any downstream revenue.*

E. Future of Family Medicine at The Christ Hospital and Recommended Action Steps

The previous sections of this report reveal a strong foundation and start for Family Medicine at TCH. The hospital administration offers excellent support and the program has brought patients to TCH and has a positive contribution margin. In return the community benefits in multiple ways through the programs many clinical and educational activities. A clear benefit is producing family physician graduates who decide to stay, facilitate access and provide care for patients who live in Greater Cincinnati. This is a valuable partnership for Family Medicine, TCH and the Community.

What may lie ahead in the future? The hospital Board of Trustees has a goal for TCH being a Top Ten hospital across all metrics. It follows that TCH's GME Programs should strive to be Top Ten programs in their specialty areas—this sets an overarching goal for the future. To move in that direction the vision of the future must consider the significant environmental trends and factors shaping the delivery of health care and consider how these impact primary care and specifically for this report, Family Medicine.

Trends in US Health Care	Possible Response(s)
Primary Care workforce shortages; overworked primary care physicians; marginal primary care physician remuneration	Build and support the pipeline for primary care and geriatrics
Health System Re-engineering 1) Increase Safety of the delivery system 2) Quality Improvement 3) Pay-for-Performance	Support infrastructure to increase patient safety, improve quality and facilitate physicians achieving good outcomes and remuneration
Demographic changes: aging population, more chronic disease	Train geriatric workforce; train for the chronic care model.
Increase Value (control costs); good outcomes at the best price	Ongoing review of costs of care in the primary care offices
Emphasis on Prevention/Wellness and patient responsibility for health	Introduce wellness and prevention programs at a systems level
Increased Recognition of the Value of Primary Care—e.g., Patient Centered Medical Home concepts	In primary care offices, support the key concepts of the patient centered medical home/characteristics of primary care.
Population Based Medicine—Health of a Community; improve access for all.	Monitor the health of patients in our primary care offices; monitor access to care
Ongoing Innovation/Implementation of Information Technology—Better EHRs	Continue to support and introduce state of the art information technology for physicians.
Increasing use of hospitalists and increased need for coordinating care across the continuum of care	Create improved systems for coordination of care across the continuum of care

The future of Family Medicine at TCH must include a response to each of the trends above. As stated in other sections, family medicine cannot thrive without strong partners that come along side and provide key financial resources to the human capital the department provides. As a social good, Family Medicine cannot achieve its highest value to a community without strong partners and financial support. This investment by key partners should be lead by mutual goals and value to the partners and to Family Medicine.

We offer two sets of recommended action steps: 1) to move in the direction of a being Top Ten program and 2) to partner with the hospital in improving the health of the community through the creation of a TCH based primary care foundation.

1. Actions Steps to Move Toward a Top 10 Program

This five year review identified a set of opportunities that if addressed could take the program to a top performing program.

Problem	Opportunity/ Initiative
Forest Park FMC is too far from TCH, too small, insufficiently resourced, offers an older model of practice	**Create a new FMC** on the TCH Campus that is of sufficient size, and supports a new model of practice built around the concepts of primary care and the patient centered medical home
OB training experiences receive low evaluations and some of the experience occurs at GSH due to insufficient delivery volume at TCH.	Continue to grow OB volume at TCH MOB prenatal clinic, and in the new TCHMA MOB practice. Develop improved partnerships with current OB groups at TCH. **Hire an obstetrician** for the Family Medicine residency group at TCH.
Some rotations and experiences are rated less than satisfactory.	Introduce improvement plans for each rotation to be rated at a minimum of 4 on a 6 point scale or very good to excellent. The program has developed an innovative Curriculum goals and objective document. This document could be further refined and published for a wider audience.
Introduce emerging concepts in the US Health care Delivery System in the curriculum	**New topics for curriculum goals and objectives**; new learning activities: examples ~Health System Re-engineering 1) Increase Safety of the delivery system in Primary Care 2) Quality Improvement 3) Pay-for-Performance ~Train for the chronic care model. ~Monitor the health of FMC patients; Health/Disease of Populations; enhanced role of Family Physician in community Health ~Wellness programs; office based counseling around wellness ~Care coordination across the continuum.

1. *A New Family Medicine Center, Increase Alignment with TCH, Grow Family Medicine Offices in the community*

The Department of Family Medicine and TCH agree that a new FMC is needed to take the program to the next level. A new FMC would be expected to improve recruitment to the program. Historically, the Family Medicine residency training program has had periods when it attracted some of the best physicians who were choosing family medicine as a specialty choice. That occurred when the program was based at Mt. Airy and had a well resourced, convenient FMC in a hospital where Family Medicine residents were the only residents in the hospital. Other niche programs were also offered. UC medical students recognized that the program rotations offered considerable autonomy, a hospital environment supportive of family medicine, convenience, and an spacious, state of the art FMC.

A new FMC would be of sufficient size, incorporate the elements of the patient centered medical home, and be in close proximity to the hospital. A new FMC would be sited to accomplish the mutual goals of the training program and TCH—an FMC of sufficient size and in close proximity to the hospital, and the hospital's ambulatory strategy—growing and securing a stream of patients and physicians who utilize TCH as their preferred hospital.

The new FMC would become a TCHMA office and in this way would create a model training center that is completely separate from APC. In this way the program would achieve increased alignment with TCH.

This scenario would also include a strategic partnership with TCHMA and TCH to create TCHMA Family Medicine offices in selected communities in Greater Cincinnati. TCHMA could further develop ambulatory offices with Family Physicians. Rather than buy practices, one concept would be to begin with Family Physicians from UC Family Medicine who have existing practices, relocate them in a practice that is in a community that would retain some of those patients and allow for growth. In time program graduates could join these practices and allow for further growth to a size of 2-4 person practices individuals.

2. *Develop a strong OB Section and Consolidate Training Experiences for OB at TCH.*

The residency is required to train all residents in obstetrics. However, the program for multiple reasons has too few deliveries at TCH, and as a result has sent residents to Good Samaritan Hospital for a month to get sufficient volume. This experience typically leads to adequate delivery numbers, but is variable, is difficult to control and oversee; it is run by the OB-GYN Dept at Good Samaritan.

The primary objective is to have enough volume at TCH to eliminate the need to work at GSH. To accomplish this one strategic initiative is to grow the current volume of obstetrical patients in the MOB Prenatal Clinic, and in the Family Medicine Centers. This has occurred albeit slowly in the first five years. Another strategic initiative is to hire an obstetrician within the Department of Family Medicine. This could lead to further growth of delivery volume, and in addition address the cultural issues of Family Physicians delivering babies at TCH. For TCH, the ideal mix of faculty would include family physicians, obstetricians, and nurse midwives.

3. *Continue to enhance and improve each rotation in the residency; publish the program's curriculum goals and objectives.* The current nationally recognized niche programs and

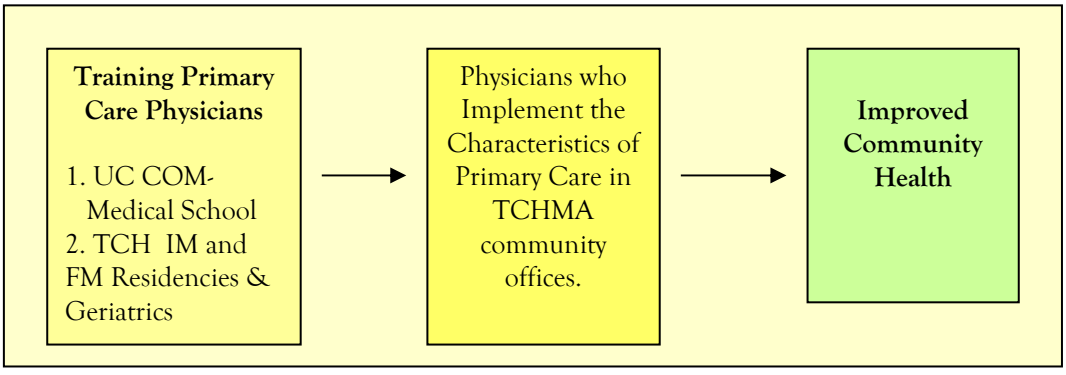
experiences in Global Health and the Family Medicine-Psychiatry need continued refinement and support. In addition, each rotation and longitudinal experience can continue to be improved for resident education. One of the goals of the program would be to have no rotation evaluated lower than a 4 on a 6 point scale. To accomplish this the program would create resident-faculty teams to address each rotation, work with specialist colleagues to refine the goals, objectives and learning activities and evaluate the progress. The curriculum goals and objective document could be further revised and pursued for publication. This would bring notoriety to TCH and the University of Cincinnati.

4. *Continue to introduce emerging or evolving concepts in the US Health care delivery system in the Residency Curriculum.* As listed in the table above there a number of important concepts that are being introduced into ambulatory practice. These concepts can be incorporated into the residency curriculum to better prepare residents for future practice that is characterized by patient safety, improved quality, and better outcomes. This will enhance the program's reputation as a national level.

2. Action Steps for Establishing a Primary Care Foundation at TCH to Develop High Quality Primary Care and in turn, Improve Community Health

Creating a foundation that supports primary care education and research is not new in Cincinnati. Good Samaritan Hospital has the Hatton Institute that is supported by the E. Kenneth and Esther Marie Hatton Foundation whose endowment is estimated at $26.2M (12/07, IRS Form 990). The Hatton Institute is designed to secure the future of research and education at Good Samaritan Hospital, but it does not have a focused vision about enhancing primary care that leads to improved community health. The Hatton Foundation provides only limited support for primary care research; it does support a lecture series for family medicine at GSH.

TCH should consider creating a foundation to oversee the primary care educational programs (Internal Medicine, Family Medicine and Geriatrics) and the impact of primary care on targeted health outcomes in the community. Implicit in the work of the Foundation is the recognition of the following links: 1) training primary care physicians and geriatric physicians at TCH to be equipped to provide 2) clinical care in TCHMA offices that implements the characteristics of primary care that leads to 3) improved community health.



These programs would include the educational programs, TCHMA offices, and a research arm directed toward documenting and improving the quality of care and health of the patients served by the offices.

Educational Program Support.

The goals of the foundation would include specific educational initiatives.

Education of Primary care physicians and geriatricians would be the basis for growing a strong primary care medical staff who use TCH as their preferred hospital. This is an important long-term objective for the hospital, but the hospital has few sites in which graduates in family medicine can enter. One important environmental threat that a foundation would buffer against is the ongoing reduction in support of graduate medical education by CMS. With the growing cost of health care, ways to reduce costs are a constant at CMS (Medicare) which funds GME. There is higher than average likelihood that GME funding will likely be cut further though primary care and geriatrics support may be more protected from such cuts due to the projected workforce shortages for these types of physicians at the present time. The existence of a revenue stream independent of federal monies would allow the hospital to ensure its primary care and geriatrics training programs continue to meet the overall mission of TCH and the health care access needs of the Greater Cincinnati community.

Support for Family Medicine at the UC College of Medicine and for Medical Students interested in Primary Care Career with TCHMA. The local pipeline for primary care physicians begins in the UC COM and other regional medical schools. The relationship between the students and department faculty starts during the medical school years. The medical school years are important ones to attract future high quality residents. Recognizing this the foundation could provide some support to the family medicine medical student division ("Pre-doc") that would clearly be identified as originating from TCH. This could be done in two ways—one is to help provide funding for an endowed chair of pre-doctural education in the Family Medicine Department. The second would be to fund a scholarship of $25K annually for a Christ Hospital Family Medicine Scholar who would be selected during the Spring of the 3rd year, has decided on a career in Family Medicine, and will seek to match in the TCH-UC FMRTP. The money is to help offset the cost of the fourth year of medical school. The expectation of such scholars is that they will seek to match in TCH-UC FMRTP, and join a TCHMA office for two years after they graduate. A similar scholarship with the expectation of joining a TCHMA Internal Medicine office could be offered for a student who is choosing a career in Internal Medicine and is interested in the TCH Internal Medicine Program.

Support for Geriatrics/Palliative Care Fellowship. The Geriatrics Fellowship program is one of the more well known programs in the Midwest for training geriatricians. This specialty service has been on or near the top 50 geriatric services on the USNewsWR lists—clearly this is one of the hospital's strengths. This program has residents from both Internal Medicine and Family Medicine programs who participate in the geriatric curriculum. One opportunity is to expand the geriatrics program by developing a complementary fellowship in Palliative care. There are faculty from Family Medicine and Internal medicine who have been joined by TCH administration and TCH's chaplain program who are interested in starting a Palliative care

fellowship. Palliative Care programs having a growing need in the hospital to assist families with medical decision making and coordinating care. They have been shown to save costs and improve patient and family satisfaction. To start the Palliative Care program will requires some initial support, and the foundation could provide that, evaluate the quality of those services, and support care innovation in the program. Done well this could differentiate TCH from other regional hospitals.

Impacting Community Health Through High Quality Primary Care Services. *Organizational Principles of Primary Care.* TCH would proactively seek to further extend the patient care mission of the hospital beyond the walls of the hospital and into the community. The Foundation would be able to map the location of the TCHMA patients served in Greater Cincinnati and use billing and census data to better define the population served. In addition, the foundation would assist TCHMA offices in defining a set of comprehensive services typical of primary care practices; the goal is that TCHMA offices will offer a broad range of primary services. The foundation would also monitor and promote patient continuity with providers and settings and seek to encourage seamless coordination of care between office and TCH. Coordination of care from office to hospital would differentiate TCHMA offices from other primary care offices in the area. Finally, to promote good outcomes the foundation would periodically consider access barriers for patients in the TCHMA offices and those who are in the community and seek to address those. Access would be viewed both from the office and hospital perspectives.

TCHMA offices would be linked electronically and data would be regularly reviewed on the health of the populations that are served by TCHMA offices. To document benefit on community health, the foundation would have a data support infra-structure that would be able to document the health status and targeted health outcomes in the TCHMA offices. Strategic care objectives and specific disease or process of care targeted goals would be developed annually. Plans for achieving those goals would be developed and implemented at the office level. The intent of this work of the foundation would be to support physicians in defining office performance and improve specific clinical outcomes. This would provide TCHMA physicians with the support needed to improve performance and achieve improved reimbursement.

Innovation to Improve Quality of Care and Patient Safety. One of the missions of the foundation would be to advance and introduce innovation in the quality of patient care and patient safety. This would include an office of quality improvement focusing specifically on the primary care offices in TCHMA. This office would regularly assess cutting edge innovations in health care delivery through health services research and technology that emerge around the country. The office would oversee and work with the offices to introduce these innovations that have evidence to support improved clinical outcomes (e.g., chronic care model), assessing the cost of those innovations, and evaluating their success. The long-term goal would be to be recognized as a leader nationally in implementing aspects of the patient centered medical home. A Patient-Centered Medical Home has seven core features and some very specific characteristics shown in the table below:

Seven Core Features	Characteristics
A Personal physician	Greater access to needed services
Physician directed medical practice	Better Quality of care
Whole Person orientation to the patient	Greater focus on prevention and wellness
Coordination and Integration of care	Early identification and management of health problems
Quality and Safety	Lower per person costs
Enhanced Access	Lower emergency room utilization
Appropriate Payment	Fewer hospital admissions
	Fewer unnecessary tests and procedures
	Less Illness and injury
	Higher patient satisfaction

What is apparent by scanning the lists of core features and characteristics is that Starfield's characteristics of primary care and the outcomes of that type of systemic organization can lead to the outcomes on the right side of the chart. This information can and should be translated into clinical practice and the payment incentives are moving in that direction. It is this sort of organizational change that the foundation can assist with in the future. Without such centralized oversight, assistance and support the needed changes are less likely to occur and will be sporadic and inconsistent at best in the different offices.

Summary: The Secret of How to Care for a Community

The future of TCH can include Top 10 GME programs in Family Medicine, Internal Medicine and Geriatrics, and can impact the health of the Greater Cincinnati community through extending and enhancing its mission beyond the hospital campus and into the primary care offices. To do the latter will require solidifying its relationships with current and future primary care physicians. Such relationships can be solidified by engendering loyalty to TCH beginning in the training years during the student years in the UC College of Medicine and during residency and fellowship training at TCH, and by establishing an infrastructure to support high quality clinical care and patient safety in TCHMA primary care offices. A foundation would facilitate the relationships between hospital and primary care physicians that will lead to ongoing utilization of the hospital and referrals to specialist groups while at the same time improving the health of the community. Promoting the health of the community is now at the leading edge of health care, and it is becoming more apparent that the secret of the care of the community is to first train and equip the care-givers.

Appendix 1: How a Family Physician Functions as a Patient's Health Advisor

How Your Family Physician Serves as Your Personal Health Advisor

Sees you across all *Seasons of Your Life*	**Birth/Infancy(1)**	**Toddler (1-3)**	**Juvenile (3-12)**	**Adolescence (12-22)**	**Young Adult (22-40)**	**Middle Adult (40-60)**	**Late Adult (60-75)**	**Old Age >75**	**Death**
		Acquisition: Language & Motor Skills	Social Awareness and boundaries Emergence of self concept	Puberty to Physical Maturation Peer vs Parental Influences Training for adult roles & responsibilities Awareness of strengths/ weaknesses	Time to Commitment Life work: occupation Marriage: spouse New Family Unit & Parenthood Settling Down	Stock taking / Reflection Decline in Physical Function Acquiring Wisdom Death of Parents	Satisfaction vs Regret Further Decline in Physical Function Retirement	Dependency on others 	
	Infants, Children, and Adolescents				Adults			Elderly	

Seeks to Understand You as a *Whole Person* And Establish a *Continuous Relationship*	**YOUR BODY**	**YOUR MIND**	**YOUR SPIRIT**	**YOUR FAMILY**	**YOUR COMMUNITY**	**YOU AS PATIENT**
	Genetics: Inherited Risk for Disease, Race *Physiology*: Internal Processes *Anatomy*: Physical Features	Personality Mood & Emotions Motivations Defense Mechanisms Neurodevelopmental capacities Multiple Intelligences	Beliefs Conscience: Free Will/ Choices: guilt or contentment Transformation toward the good: desire, training, maturation Faith Community: rituals Implications for health, care	Home environment Role(s) Relationships Health Beliefs Health Habits Socioeconomic class Health Coverage	Friends/support Relationships Occupation Work Environment Leisure activities Civic Involvement Community Health	Your understanding of health problems Your level of concern about health Recent life events or stressors Coping Mechanisms

Provides *Primary Care That Includes a "Comprehensive Basket of Health Services"*	**WELL CARE & PREVENTIVE CARE**	**MATERNITY CARE***	**MENTAL HEALTH CARE**	**ACUTE HEALTH CARE**	**CHRONIC DISEASE CARE**	**END OF LIFE CARE & HOME CARE**	**ADMINISTRATIVE SERVICES**
	Health Assessment: evaluate health status and risk for disease Health Promotion: adopt a healthy lifestyle, immunizations Anticipating health problems	-Prenatal Care -Low Risk Obstetrical Patients * though all have been trained, not all deliver maternity services	-Counseling for good mental health -Diagnosis and management of common mental health problems: e.g., Depression, Anxiety	Diagnosis and Management of acute injuries and illnesses: e.g, sprains, flu, sinusitis, urinary infections	Diagnosis and Management of chronic diseases: e.g., Diabetes, High blood pressure, heart disease, Emphysema, high cholesterol	Supportive Care	-Advocating for you in the health system -Working with your employer or your health plan -Filling out forms -Ordering Tests
	Patient Education and Support for Self-Care						

Coordinates Your Care in the Local Health System	**Individualized Treatment Plans You Understand**	**Coordinating Specialists Care and Care in the Hospital**
	Diagnosing problems, Designing Treatment Plans Customized for You and Explaining this in Terms You Understand	**Identify Problems Needing Referral and Consultation with other Specialists or Hospitalization**

Appendix 2: Principles of Family Medicine As it Relates to Curriculum

Equipping a Family Physician to Function as a Patient's Personal Health Advisor: *Linking Curriculum and the Foundational Principles of Family Medicine with the*

The Curriculum: *Educational Experiences*

- Adult Medicine Hospital Based Family Medicine (6 months)
- Adult Medicine Hospital Based Intensive Care Unit (1 month)
- Adult Medicine Ambulatory Cardiology (1 month)
- Adult Medicine: Elderly Geriatrics & Home Care
- Adult Medicine Ambulatory Emergency Medicine
- Pediatrics Ambulatory Emergency Medicine
- Pediatrics: Ambulatory General Pediatric and Sub-specialty Clinics)
- Pediatrics: Hospital Based Pediatric Inpatient Service
- Pediatrics: Hospital Based Newborn Nursery Service
- Women Care Obstetrics (2 months)
- Women Care Gynecology
- Surgery Hospital Based General Surgery Service
- Surgery Ambulatory Based
- Subspecialty Surgery Orthopedics
- Subspecialty Surgery Otolaryngology (ENT)
- Subspecialty Surgery Opthalmology
- Subspecialty Surgery Urology
- Community Medicine/ Care of Underserved/ International Health
- Behavioral Medicine Introductory Block
- Dermatology
- Radiology/Nuclear Medicine
- Sports Medicine
- Health Systems Management & Practice Management
- Conference Series/ Behavioral Medicine
- Scholarly Activity
- Electives

Family Medicine Center Experience: Medicine of the Whole Person

Centrality of Family Medicine Center (FMC)

The FMC experience is foundational for training family physicians. Residents see patients every week in the FMC all three years. As knowledge is gained on the various rotations, this is applied to patients seen in continuity clinic. In addition, the residents learn about the different functional roles of a Family Physician and the foundational principles of the specialty of Family Medicine.

1. Seeks to Understand a Patient in any Season of Life as a *Whole Person* and Uses This Understanding to Create Care.

Human Feature (Framework)	Season of Life (age in yrs): Birth/Infancy (0-1)	Toddler (1-3)	Juvenile (3-11)	Adolescent (11-22)	Young adult (22-40)	Middle adult (40-60)	Late adult (60-75)	Old age (>75)
Biological								
Psychological								
Spiritual								
Family/Social								
Community								
Person as Patient								

2. Establishes *Continuity* Relationships With Patients and Is Able to Use and Manage Multiple Types of Physician–Patient Relationships.

Types of Physician-Patient Relationships
Paternalistic
Mutual Collaboration
Patient-Centered

3. Provides Primary Care That Include "*Comprehensive* Basket of Health Servic in Multiple Settings

Type of Service
Well Care & Preventive Care
Maternity Care
Mental Health Care
Care of Acute Health Problems
Care of Chronic Health Problems
End of Life Care & Home Care
Administrative Services
Procedural Care

The Product: Primary Functions of the Family Physician

How well does the curriculum promote: 1) The Functional Development of a Family Physician?

2) The Foundational Principles of Family Medicine?

10. Committed to carrying out Professional Responsibilities, Adhere to Ethical Principles, and Continue to Stay Current and Competent as a Physician

Continuing Medical Education
Regularly engages in reading, courses, etc, that adds skills and knowledge
Continually seeks to improve individually and the health system

9. Seeks to Understand the Determinants of Health in the Population and Is Active Creating Population Interventions to Solve "Upstream Problems."

Determinants of Health in a Population
Physical Environment
Socio-economic Environment
Culture
Genetic
Health System

8. Pr

Creating Patient-Centered, (Whole Person) Care: Approach to patient care that places the patient's problems into one or more contexts that give the problem meaning to the patient, the physician, and the doctor-patient relationship.

Continuity of Care: Develops ongoing relationships between the doctor and the patients from infancy to old age, in health and disease with special emphasis on the family.

Comprehensive Care: Able to provide a broad spectrum of services

Coordination of Care: The process of organizing and orchestrating the services to meet the unique health care needs of each patient in all settings.

Access to Care: Commitment to providing access (obtain health services when needed) to care for ***all*** patients.

Mar Care

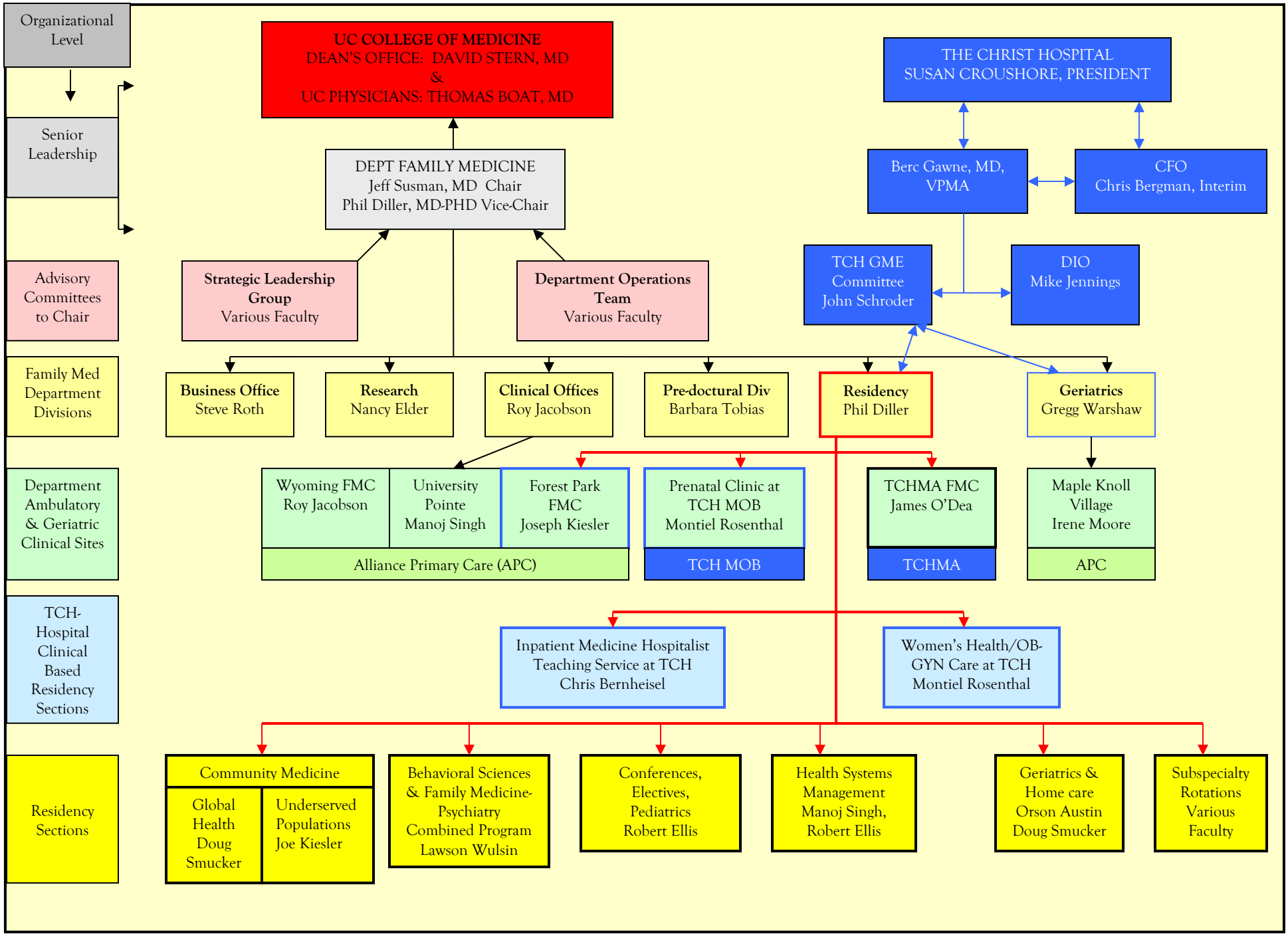
Providi in th effici respo

Approach to the Patient | Scope of Services and Practice | Approach

Foundational Principles of Family Medicine

References: Residency Review Requirements for Family Medicine (ACGME); *Future of Family Medicine* Monographs (Annals of Family Medicine 2, Suppl 1 S1-S99:
Saultz JW. Textbook of Family Medicine. McGraw-Hill. 2000. McWhinney IR. A Textbook of Family Medicine. 2nd ed. Oxford Univ Press

Appendix 3. Department of Family Medicine Organizational Chart Highlighting the Residency


Organizational Level
Senior Leadership
Advisory Committees to Chair
Family Med Department Divisions
Department Ambulatory & Geriatric Clinical Sites
TCH-Hospital Clinical Based Residency Sections
Residency Sections
UC COLLEGE OF MEDICINE
DEAN'S OFFICE: DAVID STERN, MD
&
UC PHYSICIANS: THOMAS BOAT, MD
THE CHRIST HOSPITAL
SUSAN CROUSHORE, PRESIDENT
DEPT FAMILY MEDICINE
Jeff Susman, MD Chair
Phil Diller, MD-PHD Vice-Chair
Berc Gawne, MD, VPMA
CFO
Chris Bergman, Interim
Strategic Leadership Group
Various Faculty
Department Operations Team
Various Faculty
TCH GME Committee
John Schroder
DIO
Mike Jennings
Business Office
Steve Roth
Research
Nancy Elder
Clinical Offices
Roy Jacobson
Pre-doctural Div
Barbara Tobias
Residency
Phil Diller
Geriatrics
Gregg Warshaw
Wyoming FMC
Roy Jacobson
University Pointe
Manoj Singh
Forest Park FMC
Joseph Kiesler
Alliance Primary Care (APC)
Prenatal Clinic at TCH MOB
Montiel Rosenthal
TCH MOB
TCHMA FMC
James O'Dea
TCHMA
Maple Knoll Village
Irene Moore
APC
Inpatient Medicine Hospitalist Teaching Service at TCH
Chris Bernheisel
Women's Health/OB-GYN Care at TCH
Montiel Rosenthal
Community Medicine
Global Health
Doug Smucker
Underserved Populations
Joe Kiesler
Behavioral Sciences & Family Medicine-Psychiatry Combined Program
Lawson Wulsin
Conferences, Electives, Pediatrics
Robert Ellis
Health Systems Management
Manoj Singh, Robert Ellis
Geriatrics & Home care
Orson Austin
Doug Smucker
Subspecialty Rotations
Various Faculty

Appendix 3: Faculty Biographies, Faculty & Resident Awards
Residency Faculty Brief Biographies

Philip M. Diller, MD-PHD, Program Director. Dr. Diller is a former chief resident and a 1991 graduate of the program. He joined the faculty straight out of residency and became residency program director in October of 1999. He believes that a true medical education is a trans-generational one and seeks to introduce his learners to contextual frameworks that have a historical foundation. Dr. Diller is unique in garnering a number of teaching awards: 2005 Ohio Academy of Family Physicians Teacher of the Year; 2006 American Academy of Family Physicians Full-time Teacher of the Year, and 2007 University of Cincinnati AB "Dollie" Cohen Teaching Award. He has annually been on Cincinnati's Best Doctor's List since 2004. He has consistently received high performance evaluations for his leadership of the residency by the residents, faculty, and peers. He has been involved in the residency's global health program from the very beginning; he was the first resident to go on an international trip in 1990. He continues to teach on the inpatient service, in Honduras, in the Family Medicine Center, prenatal clinical and for the resident conference series.

Joseph Kiesler, MD, Associate Program Director, Director of Underserved Track, Medical Director at Forest Park through 1/09. Dr. Kiesler is a former chief resident and 1997 graduate of the program. Dr. Kiesler has an active interest in health policy and providing health care for uninsured and homeless patients who live in Greater Cincinnati. He was part of an office start-up on Winton Road in 1997 and was the Medical Director for that office, helping guide an EMR implementation. He started an Underserved tract for the residency at the Mt Healthy FQHC in 2003 which is now part of the Health Care Connection. He oversaw residency training in that site until 2006 when he became Medical Director for the Forest Park FMC. He has been President of the Center for Respite Care of Greater Cincinnati, a temporary unit for homeless patients who need a place to go after hospitalization, but before being able to be discharged back to the street. In 2003 he was selected as one of the "40 Under 40" group of professionals in Greater Cincinnati. He was selected as one of Greater Cincinnati Health Care Heroes in 2007 for his work with the homeless.

Christopher Bernheisel, MD, Director of Inpatient Family Medicine Hospitalist Service. Dr. Bernheisel is a former chief resident who graduated from the program in 2005. Dr. Bernheisel was a member of the Global Health and Underserved Health tracks and did his continuity training at the Mt. Healthy Family Medicine Center. After graduation Chris was appointed director of the Family Medicine Hospitalist Service at TCH. This service is the foundation for hospital medicine for all family medicine residents. He has an active interest in studying and introducing new teaching methods on the inpatient service, and regularly models and teaches

"evidence based medicine." He is highly regarded by other medical staff in the hospital for his broad and deep medical knowledge base that translates into superb care. In 2008 he was recognized by his peers as one of Cincinnati's top hospital physicians as included in Cincinnati Magazine's issue of Top Doctors.

Montiel Rosenthal, MD, Director of Maternity Services and Prenatal Clinic. Department Director of Family Medicine at Cincinnati Children's Hospital. Dr. Rosenthal is a former chief resident who graduated from the program in 1989. The following year she completed her Noviate as a Sister of Charity. She volunteered at Decatur County Maternal and Child Health Center in Greensburg, Indiana. Following this she completed an OB Fellowship at St. Elizabeth Medical Center in Northern Kentucky. From 1991-1997 she helped direct and staff one of the primary care outreach clinics as part of St. Claire Medical Center in Morehead, Ky. From 1997 to 2002 she was a medical missionary in Armenia, Eastern Europe. She returned to the St. Claire System in for 2002 and 2003 before joining the Department of Family Medicine in 2003. She is one of the few faculty role models who practices full scope family medicine—ambulatory, hospital, obstetrics and a large set of procedures.

Douglas Smucker, MD through 12/08. Director of International/Global Health Track, Palliative care. Dr. Smucker is a 1987 graduate of the Medical College of Ohio (Toledo) Residency where he was the third year chief resident. He followed that residency with one in Preventive Medicine while completing an MPH in Epidemiology at the University of North Carolina. He was also a Primary Care Faculty Development Fellow, a fellow in Primary Care Research, and has extensive training in Palliative and End-of-Life Care from Kings College, London, Northwestern University and Harvard University. Currently Dr. Smucker directs our International Health/Global Health elective which occurs twice annually. His care and service to the underserved is without equal and is apparent through his volunteerism at Crossroad Health Center and at other inner city venues as well as international sites where he provides volunteer medical services. Dr. Smucker is a mentor and role model to residents and medical students alike in several areas: epidemiology in a medical student course, for continuing the mostly-lost art of home visits and for providing sympathetic and superb palliative care. In 2007 Dr. Smucker was awarded Caregiver of the Year by Vitas Innovative Hospice Care in Cincinnati. He has been recognized multiple times by the residents for his teaching skills.

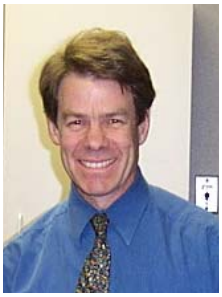
Jeff Schlaudecker, MD, Hospitalist, Geriatrician. Assistant Director of The Christ Hospital/University of Cincinnati Inpatient Family Medicine Service. Jeff is a 2006 graduate of the residency program who also served as chief resident in his third year. He undertook the Geriatrics Fellowship with the U.C. Division of Geriatric Medicine and joined our residency faculty in July 2007. Jeff has continued his interest in geriatric populations and has presented in this vein on nosocomial infections as well as

pneumonia and c-diff associated diarrhea. Jeff serves on the Family Centered Care Committee at The Christ Hospital. He and his wife, a pediatrician, have undertaken medical missions in several areas of the world. He is involved in our global health track.

Orson Austin, MD, Geriatrician, Forest Park Practice. A 1991 graduate of our program, having served as a chief in his third year, Dr. Austin went into group practice following his residency while remaining a residency faculty physician and teaching and mentoring both residents and medical students. He undertook a Geriatric Medicine Faculty Scholar Development Fellowship and subsequently served as the director for the Faculty Development in Primary Care Fellowship. He continues to work with geriatrics patients, with patients in need of compassionate and quality palliative care, is a reviewer for The Journal of Family Practice, is a member of the NBME Computer Based Case Simulation Scoring Committee, and still practices, precepts and mentors medical students and residents at our busy Forest Park site. He is also involved at a community level in the Alzheimer's Association of Greater Cincinnati, serves on the board of Crossroad Health Center and is a parish council member of St. Agnes Church.

Kathleen Downey, MD, Wyoming Family Medicine Center Physician; Coordinator of Departmental Grand Rounds. A 1982 graduate of the program first practiced on the West side of Cincinnati as a medical director of an Urgent Care Center. She has also practiced on a Navajo Indian Reservation, on the Bering Sea in Alaska, and in New Zealand. She moved to the Wyoming Family Practice Center for her practice in late 1980s. Kathy has been part of the residency since 1993 and has broad experience to drawn on as a teacher. Besides a very busy and productive practice, she precepts regularly in the Forest Park FMC. Her strengths include well women care, travel medicine, and procedures. Her expertise includes primary care radiology and the neurologic examination.

Robert "Rocky" Ellis, MD, Director of Conferences, Electives, and Pediatrics. A 2005 graduate of the program and a former chief resident, Dr. Ellis joined the Department immediately out of residency. In the residency Rocky oversees the conference series, resident electives and the pediatric educational experiences. Rocky is one of the few department members who is active in two divisions—residency and pre-doc. He also has a very active practice at the Wyoming Family Practice Center.



Lawson Wulsin, MD, Director of the Family Medicine-Psychiatry Program, Director of Behavioral Sciences. Dr. Wulsin has joint appointment with the U.C. Department of Psychiatry and the Family Medicine residency program. He came to our program with a varied background in Psychiatry which includes a fellowship in cognitive therapy, two years as an NIMH Fellow, an appointment as a visiting professor at the University of Nairobi and many years

of teaching medical students and residents. He was a 2003 Cincinnati Magazine "Top Doctor" for Psychiatry and has won awards from residency classes for his teaching prowess. Dr. Wulsin has participated in the global health site visit to Honduras on several occasions and has a longstanding research project involving depression in mothers with children under age 5. He also was involved in the study of the Rwandan Genocide of the 1980's.

New Faculty for 2008-2009.

Jeff Morgeson, MD, Hospitalist. Jeff graduated from the program in 2006. He was involved in the global health track of our program and undertook several brigades to rural Honduras. In January 2006, he served as the team leader for 55 health care providers in rural Honduras. After graduation, Jeff spent a year in clinical practice awaiting clearance for a year of locums tenens work in New Zealand. He returned to the program and remains involved in our global health track and serves as a hospitalist on our Family Medicine Inpatient Service at TCH.

Christopher White, MD, J.D. Associate Director of the Family Medicine-Psychiatry Program. Chris is a 2007 graduate of the combined Family Medicine-Psychiatry program and was a chief resident for 2 years. As a resident he was very successful grant writer, editor, author and was the recipient of two notable fellowships American College of Psychiatrist Laughlin Fellow and the Academy of Psychosomatic Medicine Webb Fellow. He has joint appointments in the Department of Psychiatry and the Department of Family Medicine. In Psychiatry he is director of the inpatient psychiatry consultation service. He has considerable commitment of time for developing a research agenda. He as recently award one of the fellowships for the national grant generating project in family medicine. His role in the residency is to further development the combined curriculum.

Christy O'Dea, MD, Director of International/Global Health beginning January 2009. A 2000 graduate of the program and a previous chief resident, Christy first practiced in Washington State where she also precepted in a family medicine residency program. She then moved to WI where she co-established a free clinic. She was involved in all aspects of patient care including inpatient medicine and nursing home rounds. She then fulfilled her desire of volunteering for a time in an international medical missions site and moved with her family to rural Honduras. She raised the funds necessary to practice at an established clinic to which the TCH/UC Family Medicine Residency Program has traveled and continues to travel to provide long term care. Christy also became a faculty preceptor in Honduras. Upon termination of her 2 year commitment, she returned to Cincinnati where she plans to practice beginning in January 2009 and will serve as Director of our International/Global Health Track.

James O'Dea, MD. OB Section Faculty and The Christ Hospital Medical Associates Practice. James is a graduate of the program from 2000 and was a chief resident. He left the residency and undertook a Fellowship in High Risk Obstetrics in Tacoma, WA where he also served as faculty and practiced at the Tacoma Family Medicine Residency. James then took a position at a site in WI where he co-established a free clinic. He continued practices the full spectrum of Family Medicine including high risk OB. He then raised funds to move his family to rural Honduras to practice at an established clinic to which the TCH/UC Family Medicine Residency Program has traveled and continues to travel to provide long term care. He thus became a faculty preceptor for our program in Honduras. Upon termination of a 2 year commitment, James returned to Cincinnati where he has taken on the role of Medical Director of TCH Medical Associates Family Medicine practice which opened on November 1, 2008. He is part of our OB call team and continues to work with our International/Global Health Track.

Reid Hartmann, MD, Underserved Medicine and TCHMA MOB Practice. Dr. Hartmann is a 2006 graduate of the program and a former chief resident. Immediately after graduated Reid began working at the Cincinnati Veterans Administration Hospital. He joined the Department of Family Medicine in October, 2008. He grew up on the west-side of Cincinnati and currently lives in Over-the-Rhine. He is very civic minded and active in promoting the redevelopment of his community. He is one of the founding members of the new TCHMA Family Medicine office in the MOB. He will be involved in the underserved curriculum, help staff the homeless Van, and serve as a liaison to the Department's Pre-doc division.

Jennifer Spata, MD, OB Section and TCHMA MOB Practice. Jennifer is a 2008 graduate of Valley Medical Center in Renton, WA. Jennifer is returning to her city of origin as a second generation family physician. She brings proficiency and interest in many areas of women's health including OB, circumcision, colposcopy, IUD placement, and endometrial biopsy. She was the clinic team leader at Valley Medical Center and as such, she developed efficiency in the total patient interaction and in the use of EMR; as well, she developed skills in practice management. She will be part of our outpatient TCHMA office and also part of our maternity services faculty starting January 2009.

Residency Administrative Staff

Judy Flick has a knack like no other for the rotational scheduling of our residents which involves much detail. She has planned and maintained the residents' rotational schedules and ensuing communication with other hospitals, departments and private offices with aplomb. She serves on the TCH GME Committee and the Residency Faculty Committee.

Sharon Mullen oversees our residency recruitment process and works with the international health program. Sharon serves on the Recruitment Committee. She speaks Spanish and works with the Spanish Ministry at her church as well as volunteering her ASL experience interpreting services for the deaf.

Renee Baird is part time but has worked for the past 11 years with the program as the outpatient family medicine center scheduling coordinator. She works miracles with the computerized physicians' schedules- those of the residents as well as those of the faculty.

HONORS, PUBLICATIONS, PRESENTATIONS, & COMMUNITY SERVICE - FACULTY	
Orson Austin, MD	***Honor*** 2008 Cincy Magazine "Cincy's Best Doctors in Family Medicine" ***Publication*** Wigle PR, Ellis R, Austin OJ, Kiesler HJ, Drug Dilemmas/Picking a PPI: It comes down to cost. J Fam Pract, Vol. 57, No. 4, April 2008. ***Presentations*** 2008 "Home Visit Teaching: Innovations for Learners from Multiple Levels of Training," Smucker D, Austin O, et.al. Oral Presentation, OH Family Medicine Symposium on Research and Education October 2007 "Hospice Pharmacia Nationwide," 18th Annual Statewide Geriatric Conference, Salt Fork, OH
Christopher Bernheisel, MD	***Honor*** Voted 2008 Cincinnati Magazine "Top Doctors of the Year" in Hospital Medicine. ***Publications*** Bernheisel CR, Schlaudecker JD, Managing CAP: An evidence-based algorithm, J Fam Practice, 2007, 56(9), 722-6. Bernheisel CR, Schlaudecker, JD, Nephrogenic Systemic Fibrosis, Pending publication, J Fam Practice. ***Presentation*** Family Medicine Grand Rounds December 2007, "New Standards of Care: Pneumonia, CVA and Cellulitis."
Philip Diller, MD	***Honors*** 2008 Cincy Magazine "Cincy's Best Doctors in Family Medicine" University of Cincinnati AB "Dolly" Cohen Award for Excellence in Teaching, 2007. American Academy of Family Physicians Exemplary Fulltime Teacher of the Year Award, 2006. Ohio Academy of Family Physicians Teacher of the Year, 2005. ***Publications*** Bazemore AW, Henein M, Goldenhaar LM, Szaflarski M, Lindsell CJ and Diller, PM. The Effect of Offering International Health Training Opportunities on Family Medicine Recruiting. Fam Med 2007, 39(4), 255-60. Heck, JE, Bazemore AW, Diller, PM, The Shoulder to Shoulder Model-Channeling Medical Volunteerism Toward Sustainable Health Change. Family Medicine, October 2007. ***Presentations*** 2006 Poster Presentation: Association for Hospital Medical Education. "Alarm Bells for

	Resident Training: A Tool to Identify Problematic Behaviors in Resident Trainees." Filak AT, Diller PM.
Kathleen Downey, MD	***Publication*** Pending article on Excision Biopsies. Submitted to UpToDate. ***Presentation*** "Osteoporosis" 17th Annual Statewide Geriatric Medicine Conference, October 2005
Robert Ellis, MD	***Publications*** Ellis R and Ellis C. Consultations and Comments: Ringworm as a zoonotic infection, Consultant. 2008 (accepted.) Ellis R and Ellis C. Tularemia, Essential Evidence Plus, An electronic EBM resource. 2008 (accepted.) Ellis R, Newsletter Column, The Clinical Case of the Week, **The Monday Morning Quarterback**, This is a weekly newsletter electronically delivered to the faculty in the Department of Medicine and the community preceptors that teach FM Clerkship Students, Dec. 2007 - present. Ellis R and Ellis C. Teaching Points—A 2 Minute Mini-lecture: Toxoplasmosis Counseling in Pregnancy, The Teaching Physician (excepted, to be published in July 2008). Wigle P, Hein B, Ellis R, Austin O, Kiesler J, Galt K, Picking a PPI: It comes down to cost, The Journal of Family Practice 2008 (57:4) pp 231-236. Ellis R and Rosenthal M. Chapter 62: Urticaria, Ambulatory Medicine: The Primary Care of Families, 5th Edition, McGraw-Hill (accepted, to be published in the Summer of 2008). Ellis R, Gebhardt B, Elder N. Teaching Points—A 2 Minute Mini-lecture: A Medical Mistake, The Teaching Physician 2007 (6:1). ***Presentations*** Integrating Family Medicine Clerkship didactic sessions and preceptor teaching with a weekly newsletter. Ellis R and Friemoth J, STFM Conference on Predoctoral Education, January 2009, (Accepted). The Use of Patient Cases across the Educational Spectrum. Ellis R, OAFP Symposium on Research and Education, April 12, 2008. Rabies and Scabies and Bites, Oh My! Ellis R and Ellis C, 60 minute Seminar, AAFP 2007 Scientific Assembly, given twice on October 4, 2007. This program received special recognition as an Annual Clinical Focus Presentation. Third-year Family Medicine Preceptor Grades: The Differences Between Community, Faculty, and Residency Evaluations of Student Performance, Gebhardt B and Ellis R. Poster Presentation, 40th STFM Annual Spring Conference, Scheduled for April 2007. Common Zoonotic Diseases, Ellis R and Ellis C, University of Cincinnati, Department of Family Medicine Grand Rounds, January 2006. ***Grants*** July 2008 – July 2009, **Grant Co-Investigator;** Tobias, Divine, and Ellis. $5000 research grant.

	Evaluation of Effective Teaching of Musculoskeletal Exam Skills and Concepts Across the Medical School Curriculum.
Reid Hartmann, MD	***Community Service*** MEDVOUC (Medical Volunteers of the University of Cincinnati). Preceptor for first and second year medical students at the homeless shelter medical clinic in Cincinnati, 2007 to present. Environmental Leadership/Green Cincinnati Steering Committee Member, City of Cincinnati, 2007 to present.
Joseph Kiesler, MD	***Honor*** 2008 Cincy Magazine "Cincy's Best Doctors in Family Medicine" 2007 Cincinnati Business Courier Health Care Hero ***Publications*** Bender MA, Kiesler HJ, Disaster Preparedness and Community Health Centers. Ohio Family Physician, Summer 2008, vol. 38. Wigle PR, Ellis R, Austin OJ, Kiesler HJ, Drug Dilemmas/Picking a PPI: It comes down to cost. J Fam Pract, Vol. 57, No. 4, April 2008. ***Presentations*** "Health problems of workers that live and work on the backside of a thoroughbred race track," Poster presentation, APHA 133rd Annual Meeting, Philadelphia, December, 2005 "Impact of obstetrical experiences at community health centers on future career paths," Amy Patton and Joseph Kiesler, Paper presentation, APHA 133rd Annual Meeting, Philadelphia, December, 2005 "Cultural Competency Curriculum for Community Health Center Staff Working with Hispanic Populations," Hamilton, Ohio February 2005 ***Community Service*** Founder & Volunteer Physician, Riverdowns Race Track Medical Clinical, Cincinnati, OH, Summers 2004-present Volunteer Physician, Center for Respite Care, 14 bed free medical clinic for the home-Less in Northern Kentucky
Montiel Rosenthal, MD	***Honor*** 2008 Cincy Magazine "Cincy's Best Doctors in Family Medicine" ***Publications*** Rosenthal MT, Episiotomy, Pfenninger and Fowler's Procedures for Primary Care, Third Ed., Elsevier; 2008 (in press) Rosenthal MT, Iterstitial Cystitis, Griffith's 5 Minute Clinical Consult, Lippincott, 2007, pp. 664-5. Rosenthal, M.T, Obesity and Pregnancy, Ohio Family Physician; 57(1): 38; 2005 ***Presentations*** "Sequential Teaching Models for Episiotomy and Fourth Degree Perineal Laceration

	Repair," Procedural Workshop at the Society of Teachers of Family Medicine Annual Spring Conference, Chicago, IL, April 2007 "A New Model for Teaching Colposcopy, Intracervical Block and LEEP," Ohio Family Medicine Symposium on Research and Education, Newark, OH, April 2007. "The Human Papilloma Virus (HPV) Vaccines," University of Cincinnati Department of Family Medicine Grand Rounds, January 2007. Pediatric Advanced Life Support - Rapid Cardiopulmonary Assessment; St. Claire Regional Medical Center; Morehead, KY; Jan. 15, 2004 "Family, Community, and Religion - An Armenian Experience;" College of Mt. St. Joseph; Cincinnati, OH; Nov. 6, 2004 Pediatric Advanced Life Support – Integration Lecture; Children's Hospital Medical Center; Cincinnati, OH; March 3, 2005 Newborn Resuscitation Program; The Christ Hospital; Cincinnati, OH; March 10, 2005 "Sequential Teaching Models for Episiotomy and Fourth Degree Perineal Laceration Repair," Ohio Family Medicine Symposium on Research & Education; Columbus, OH; April 16, 2005 Pediatric Advanced Life Support - Rapid Cardiopulmonary Assessment; Children's Hospital Medical Center; Cincinnati, OH; May 12, 2005 "Update in Outpatient Prenatal Care," University of Cincinnati Department of Family Medicine Grand Rounds; Cincinnati, OH; August 2, 2005 "Medical Acupuncture," Annual Meeting of Association of Sister, Brother and Priest Physicians; Allens Park, CO; September 10, 2005 "Family, Community, and Religion - An Armenian Experience," College of Mt. St. Joseph; Cincinnati, OH; October 27, 2005 Advanced Life Support in Obstetrics – Provider Course; Glascow, KY; November 5-6, 2005. ***Grants*** "Development of a Sequential Teaching Model for Fourth Degree Perineal Laceration Repair," Dean's Office Educational Seed Grant; University of Cincinnati College of Medicine; 2004-2006 "Bringing Women Back into the Healthcare System," Helen Steiner Rice Foundation; 2006 – Present ***Community Service*** Medical Acupuncture, Women's Health Fair, Price Hill Community Center, October 2008 Volunteer Physician, Riverdowns Race Track, Cincinnati, OH, Summers 2004-present Volunteer Physician, New Hope Clinic, Owingsville, KY, November 2002-2007
Jeffery D. Schlaudecker, MD	***Publication*** Bernheisel CR, Schlaudecker, JD, Nephrogenic Systemic Fibrosis, Pending publication, J Fam Practice. ***Presentations*** "Handling Nasocomial Infections: Update on Cellulitis, Pneumonia, and C-Diff Associated Diarrhea." 19th Annual Statewide Geriatric Medicine Conference, October

	2007. "Patient Centered Care" to the TCH Family Centered Care Committee.
Douglas Smucker, MD	***Publications*** Gee L, Smucker DR, Chin MH, Curlin FA. Partnering together? An exploratory study of current relationships between faith-based community health centers and neighborhood congregations, Southern Medicine, July 2005 Ludke R, Smucker DR. Racial Differences in Attitudes Toward Hospice Use, Survey, 2005. Susman J, Holten KB, Smucker DR. Interpreting Medical Literature: Applying evidence based medicine in practice, Book chapters for two Family Medicine textbooks edited by Robert Rakel, M.D. Family Practice Certification Review, Contributing Author in Lipsky M, King M,Susman, J, Dobo S (editors). Blackwell Publishing, Malden, Mass, 2004. Authored sections regarding hospice and palliative care, medical ethics, and community medicine. To be published in 2003 Smucker DS, Hospice and the continuum of primary care, Clinical in Family Practice, 2004, 6:299-323. Bazemore AW, Smucker DR Lymphadenopathy and malignancy, American Family Physician, 2003; 66:2103-10
Jennifer Spata, MD	***Honors*** 2007 John Dame Award for best senior resident teacher. From R-1 Class of Valley Medical Center in Renton, WA. 2005 Hunnicutt Award for Outstanding Performance in Family Medicine. 2004 Stagaman Award for senior medical student at the University of Cincinnati who displays the characteristics of family physician. ***Presentation*** "Sleep, As We Age" presented to the residents/caregivers at an assisted living facility in WA. ***Community Service*** Tar Wars Anti-Smoking Campaign, 2007-2008 Cops and Docs Anti-Violence Campaign, 2007-2008
Lawson Wulsin, MD	***Publications*** Chen Y, Guo JJ, Wulsin L, Patel NC: Risk of cerebrovascular events associated with antidepressant use in patients with depression: a population-based, nested case-control study. Annals of Pharmacotherapy 2008; 42: 177-84 Ketterer MW, Brawner CA, Van Zant M, Keteyian SJ, Ehrman JK, Knysz W, Farha A, Deveshwar S, Wulsin L: Empirically derived psychometric screening for emotional diseases in coronary artery disease patients. Journal of Cardiovascular Nursing 2007; 22: 320-325 Vieweg, VW, Julius DA, Fernandez A, Wulsin LR, Mohanty PK, Hasnain M, Pandurangi AK: Treatment of depression in patients with coronary heart disease. American Journal of Medicine 2006; 119:567-573

	Ignatowski M, Wulsin LR: Reconsidering paroxetine in pregnancy. Current Psychiatry 2006;5:45-48 Ketterer MW, Wulsin LR, Cao JJ, Schairer J, Hakim A, Hudson M, Keteyian SJ, Khanak S, Clark V, Weaver WD: Major depressive disorder, coronary heart disease and the DSM-IV Threshold Problem. Psychosomatics 2006; 47:50-55 Wulsin LR: Antipsychotics in the elderly: reducing the risks of stroke and death. Current Psychiatry 2005; 4: 75-78 Wulsin LR, Evans JC, Vasan RS, Murabito JM, Kelly-Hayes M, Benjamin EJ: Depressive symptoms, coronary heart disease, and overall mortality in the Framingham Heart Study. Psychosomatic Medicine 2005; 67:697-702 Huffman JC, Wulsin LR, Stern TA: Newly diagnosed hypertension and depressive symptoms: how would you treat? Journal of Family Practice 2005; 54: 39-46 Wulsin LR, Singal B: Do depressive symptoms increase the risk for the onset of coronary disease? A systematic quantitative review. Psychosomatic Medicine 2003; 65:201-210 ***Books*** Wulsin, LR: *Treating the Aching Heart: A Guide to Depression, Stress, and Heart Disease*. Vanderbilt University Press, Nashville, 2007. ***Book Chapters*** Wulsin LR, Barsky AJ: Psychiatric and Behavioral Aspects of Cardiovascular Disease, in Braunwald's Heart Disease, 8th Edition, 2007 Wulsin LR, Sollner W, Pincus HA: Models of Integrated Care, in Integrated Care for the Complex Medically Ill. Eds Huyse FJ, Stiefel FC, Medical Clinics of North America, July 2006, vol 90, pp 647-678 ***Grants*** Huang S, Wulsin LR: Condition monitoring for evidence-based care of psychiatric patients. Total direct costs $399,314. Approved and funded for 4/1/06-3/31/09 by the National Science Foundation. Wulsin LR, Principal Investigator, Kissela BM, Liggett S, Broderick J, Welge J: Stroke, depression, and the serotonin transporter gene. Total direct costs $27,632. Approved and funded for 5/05-6/06 by the Dean's Discovery Fund, University of Cincinnati. Wulsin, LR, Principal Investigator, Kissela BM, Benoit S: Depression and Cognitive Impairment as Predictors of Stroke Outcomes. Total direct costs $18,600. Approved and funded for 1/05-12/06 by The Neuroscience Institute, University of Cincinnati.
HONORS, PUBLICATIONS, PRESENTATIONS, & COMMUNITY SERVICE - RESIDENTS	
Melissa Bender, MD	***Publications*** Bender MA, Kiesler HJ, Disaster Preparedness and Community Health Centers. Ohio Family Physician, Summer 2008, vol. 38.
Laurie Carrier, MD	***Honors*** 2007 First Place in Case Vignette Competition, An Old Diagnosis in a "Young" Patient,

	Presentation of Neurosyphilis, University of IA Annual Medicine and Psychiatry Integrated Care Conference 2004-2005 Stagaman Intern of the Year Award for resident who best represents the ideals of Family Medicine ***Publications*** AAFP Annual Conference for Students and Residents, Kansas City, July 2008 Panel Participant for Global Health Forum Carrier, L; *Somatization Disorder*, Five Minute Clinical Consults, 15th, 16th and 17th edition. New York, Lippincott, Williams &Wilkins, 2007, 2008, 2009 Carrier, L; Wulsin, L; McNamee, M; Jacobson J; *Screening for Depression in Rural Honduras*, poster presentation at the Global Health Education Consortium (GHEC) Annual Meeting, 2008 Elder, N; Carrier, L; Schlaudecker, J; Peters, M; *Healthcare for the International Traveler*, Manual of Family Practice, 3rd edition, New York, Lippincott, Williams & Wilkins, 2008 White, C; Carrier, L; Wulsin, L; *Collateral Assets? 15 Years of Improved In-Training Family Medicine Exam scores Following Establishment of a Combined Family Medicine Psychiatry Residency*, poster presented at the Society of Teachers of Family Medicine (STFM) Annual Meeting, 2006 Carrier, L; Herbert, L; Physical Activity Levels in Irish School Children, *Trinity Student Medical Journal*, 2003; Volume 3: 28-31 ***Community Service*** Founder, Shared Medical Information Project (SMIP), May 2008-present, provides medical information via medical bulletin to underserved international sites for purpose of continuing medical education.
Lawrence Udom, MD	***Publications*** Pending publication, Tardive Dyskinesia, for 5 Minute Clinical Consult Pending publication, Narcissistic Personality Disorder, for 5 Minute Clinical Consult