EDITORS' NOTE

A Panoply of Information for the Practice of Family Medicine

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The majority of articles in this issue report on clinical conditions, adding to our knowledge base with which we practice family medicine. Topics range from childhood obesity to tobacco abuse treatment for patients with psychiatric disorders. We also have clinical papers on testing for group A streptococcus pharyngitis, incidentalomas identified in chest computed tomography exams, and a case of migraines associated with an ovarian teratoma. Others include long-term use of opioids (with information that could be surprising), and hand washing and face touching in the office. Enjoy the panoply of clinical information! We also have useful information on implementing medication reconciliation, 3 articles that relate to the integration of behavioral health into family medicine, and another 2 articles about recertification. (J Am Board Fam Med 2014;27:303–305.)

Research on Clinical Conditions

Once again we see many incidental findings on radiologic studies ordered for unrelated reasons. One difference is that the report in this issue by Espinoza et al[1] is from a family physician practice-based research network. One-third of the patients who had coronary and abdominal computed tomography scans for the purpose of the research had significant findings (the majority were benign). Of 571 participants, 4 had positive findings that led to significant interventions: 2 underwent coronary surgery, and at least one life may have been saved when the patient's leukemia was found and treated. The balance between testing and incidentalomas continues to be a struggle for physicians and patients.

Using an intensive multidisciplinary treatment program emphasizing the entire family, Endevelt et al[2] add positive news on how to reduce childhood obesity. Better yet, the results lasted over 2 years.

It may not be surprising that more regular opioid use for longer periods would be associated with increased risk of opioid overdoses, but what may be less well understood is that approximately half of opioid overdoses were among intermittent (rather than daily) users in this 3-year study.[3] Physicians should be aware of this high risk when treating patients with opioids.

Do family physicians and their office staff recommend hand washing and avoiding face touching to decrease the risk of colds and infectious diseases? What are their personal hygiene practices while in the office setting? Find out from this interesting practice-based research network observational study.[4]

Two excellent review articles are included in this issue. Cerimele et al[5] presents a review of tobacco use treatment in patients with psychiatric illness, which is often perceived as a difficult conundrum but can, as the authors note, be successful. Useful treatment strategies are presented. In the second review, Thomas and Lodhia[6] consider the evidence for newer therapies for inflammatory bowel disease.

Brief Clinical Reports

Brief reports are a favorite of our readers, and this issue includes several. Murdoch et al[7] report on a patient with an ovarian teratoma, highlighting the potential for associated multisystem manifestations, including migraine headaches. Leiva et al[8] found that ovulation predictor kits (testing for luteinizing hormone) have good potential to assist couples seeking to use fertility awareness methods. Llor et al[9] looked at whether C-reactive protein testing was useful to assist with the diagnosis of group A streptococcus pharyngitis—it was not.

Conflict of interest: The authors are editors of the JABFM.

Implementing Patient-Centered Medical Homes

Medication reconciliation is now required for "meaningful use" of electronic health records and is part of the standard of care in patient-centered medical homes. Medication reconciliation can identify patient confusion or nonadherence, pharmacy errors, and physician mistakes when writing prescriptions. The challenge remains how to best reconcile medications in a cost-effective fashion. Wolff et al[10] investigated 2 different methods in a randomized trial. The good news: something works! The bad news: more effort works better.

We value the types of activities conducted in patient-centered medical homes, and those practices that adhere to these values have better quality outcomes.[11] However, meeting the rigid regulatory guidelines set forth by the National Committee for Quality Assurance is not the same as doing many appropriate patient-centered activities. Hahn et al[12] provide interesting information on practices that are innovative but not necessarily certified by the National Committee for Quality Assurance.

Mental and Behavioral Health Care Assessment in (and with) Family Medicine

Rodriguez et al[13] looked at the real-world implementation of conducting both health behavior and mental health screening assessments in primary care practices. The report notes the most common issues reported by patients and provides many helpful details. Physicians liked the assessments, discussed the results with their patients half of the time, but feared whether they had the resources to meet patients' needs, raising the issue of the advisability of screening without the ability to provide appropriate follow-up.[14] In another report, Miller et al[15] found that rural areas are less likely to have family physicians and behavioral health providers located in close proximity. Given that colocation should help providers interact regarding the care of individual patients, integrated care is likely more difficult in rural areas. Yet Burfeind et al[16] reported differing opinions on integrating mental health and primary care services by the respective providers.

Recertification

Do rural physicians perform better or worse on the American Board of Family Medicine recertification exams? What is your guess? Schulte et al[17] provide the answers. Personally, I (MAB) think that the breadth of practice that often characterizes family practices in rural America should help physicians be more up to date than some of the more restricted types of practice of some family physicians in urban America. Similarly, physicians with partners could do better because they can share clinical questions and newly found information.

How well do groups work together on recertification modules? Elward et al[18] report on improvements in asthma care and guideline adherence through a group self-assessment module. We already know that teams working together during school at all levels—from elementary school through medical school—help individuals learn and improve, so it should not be a surprise that learning collaboratives can help family physicians improve patient care as well.

The Annual Hit Parade

This issue also includes our annual "hit parade" of the most-read articles and content usage. We are proud to report that content activity was up 53% in 2013 compared with content usage requests during 2012.[19]

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