EDITORS' NOTE

Investigating Patient-Centered Care

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This issue provides many articles reporting on research pertinent to patient-centered care, with great richness in the variety of methods and settings. Topics include disparities in the availability of care and the type of care provided (including a randomized trial), affecting elective hospitalizations on future patient satisfaction, the effect of the specific content of the after visit summary, 2 articles related to aspects of shared decision making, 2 articles considering the effects of practice culture, plus a report on divergent views on how to integrate behavioral and primary health care. Differences between academic and nonacademic family medicine practice are finally documented, with important dissimilarities in patient-centered care. Family physicians are highly involved with dementia care. An exciting report documents a high negative predictive value for a new genomic expression test for coronary artery disease in family medicine that uses combinations of gene expression instead of individual gene testing. (J Am Board Fam Med 2014;27:169–171.)

In a very important article, Oliver and coauthors[1] find that physicians have positive implicit biases toward white patients (this is bad), yet the physicians believe their biases could influence their decision making (recognition is good); however, they recommended surgery at the same rate for black and white men meeting sufficient criteria to recommend hip replacement (this is good). This article provides much more detail for the interested reader. As noted by Shi et al,[2] racial disparities continue in reporting a usual source of care as well as types of usual source of care (institutional vs. person) and accessibility of after-hours care.

Whether shared decision making (SDM) is occurring can be reported by the patient or the physician, and in this issue, we have reports from each. Approaching a large number of patients who filled a new prescription for an antidepressant, Solberg et al[3] considered the amount of patient-reported SDM in many practices in Minnesota. Half of the patients identified were excluded: 20% because they reported that their prescription was not for depression, and a quarter because their score on the 9-item Patient Health Questionnaire was not high enough to meet study criteria at the time of the data collection. On a positive note, SDM was positively associated with patient satisfaction. However, the amount of SDM was relatively low, and was lower still, for those who were older and those who were more depressed, respectively. In a separate report, Bouma et al[4] provide information that is mixed on provider-reported aspects of SDM in a safety net setting.

Making the after visit summary helpful in patient activation and self-care is a major goal. Pavlik et al[5] assess a previously unaddressed area: What needs to be in the electronic health record–generated after visit summary to enhance patient outcomes? With a healthy sample size, they considered 2 different levels of detail (given that meaningful use requires certain items), and found no difference on patient content recall or satisfaction. More work is to be done, as a meaningful after visit summary is most desirable. Maybe the meaningful use criteria do not address patient needs in this case.

In an interesting look at the cultures of clinical practices, Scammon et al[6] found that practices in the Care by Design patient-centered medical home had a variety of cultures. This means that even with a patient-centered medical home, there are many ways of going about the business of a practice. There were different satisfaction items specific to the different cultures. A caveat is that these practices are set up differently than many, with a broad group of provider specialties, and 80% of the respondents were medical assistants. We suggest clinicians think about their practice's culture type and consider the associated types of satisfiers to determine whether there are ways to ad-

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dress the negative while maintaining the positive dimensions.

Continuing the look at practice culture, and how it can trump organization, Willard-Grace et al[7] report on the outcomes of practice culture on emotional exhaustion (burnout) among staff and clinician providers. Team culture was more important to emotional exhaustion than specific team structure (what percentage of time the same physician worked with the same medical assistant or small group of medical assistants), in particular for the staff.

Another important article provides the first major look at care broadly across teaching and nonteaching sites.[8] It is well known that teaching sites care for more people who are minorities, less well educated, and either covered by Medicaid or uninsured—facts reinforced in this report. Less well known, however, is that the teaching sites had worse access scores yet better chronic disease management, including many characteristics considered patient-centered (such as patient activation, problem solving, and care coordination). This bodes well for future care provided by the residents trained at these sites, yet we need to find a way to improve access despite numerous complicating factors in teaching settings.

Physicians are highly aware that if they do what patients want, they can receive a better patient satisfaction score, yet what patients desire is not always the best medical answer. Fenton et al[9] found that elective hospitalizations in 1 year were associated with higher patient satisfaction with physicians the next year. The satisfaction was not necessarily with the same physician who admitted the patient. This is fascinating and definitely calls into question the use of patient satisfaction as a quality measure for which we can readily measure improvement and appropriate medical care. We certainly do not want to give patients medically unnecessary care to raise patient satisfaction this year or next!

Gene Expression Test for Coronary Artery Disease

The most unique article from the perspective of family physicians may be the one by Herman et al,[10] primarily because many family physicians have not heard about the genomic-based, personalized gene expression test for coronary artery disease. There are not many genomic tests used routinely in practice, but testing for predictive combinations of gene expression instead of individual genes has exploded in recent years. This particular test has been reported to have a 96% negative predictive value, meaning that the true rate of disease is quite low in patients with a negative test. This was previously studied in cardiology offices but not in family medicine. This study involved volunteer providers and patients, and diabetes was one of several important excluding conditions. There were substantial changes in medical testing plans after the test results were received—both more and less testing. This test could be most useful for patients with some risk (such as age) but atypical presentation. A high-risk patient with classic angina should be referred for further testing without getting a gene expression test. The test costs less than typical invasive cardiology testing (the authors report the Corus CAD has a list price of $1,245 and is covered by Medicare for 40 million Americans).

Women Meeting Criteria Are Willing to Stop Getting Papanicolaou Tests If…

Skelton et al[11] asked the question differently than prior studies: Would you stop getting Papanicolaou tests if your family physician recommended doing so based on national guidelines? The answer is reassuringly mostly "yes," yet prior studies had suggested a much higher rate of "no." Perhaps the key is the personal physician's involvement.

Et Cetera

Confusion is common about ordering and interpreting laboratory tests. In a study funded by the Centers for Disease Control and Prevention, Hickner et al[12] quantitate the difficulties of and provide suggestions to improve the situation. Sadly, many questions relate to patient cost and insurance coverage, in addition to a variety of other issues. Stewart et al[13] reinforce the large contribution of family physicians to dementia care: Almost all family physicians are involved in the assessment and routine care of those with suspected or diagnosed dementia. This issue also includes a clinical review of hepatitis C[14] and brief consideration of a case of split peroneus brevis tendon.[15]

In the next issue, the *Journal of the American Board of Family Medicine* will report the top read articles of 2013 and readership statistics.

References

1. Oliver MN, Wells KM, Joy-Gaba JA, Hawkins CB, Nosek BA. Do physicians' implicit views of African Americans affect clinical decision making? J Am Board Fam Med 2014;27:177–88.
2. Shi L, Chen C-C, Nie X, Zhu J, Hu R. Racial and socioeconomic disparities in access to primary care among people with chronic conditions. J Am Board Fam Med 2014;27:189–98.
3. Solberg LI, Crain AL, Rubenstein L, Unützer J, Whitebird RR, Beck A. How much shared decision making occurs in usual primary care of depression? J Am Board Fam Med 2014;27:199–208.
4. Bouma AB, Tiedje K, Poplau S, et al. Shared decision making in the safety net: where do we go from here? J Am Board Fam Med 2014;27:292–4.
5. Pavlik V, Brown A, Nash S, Gossey JT. Association of patient recall, satisfaction, and adherence to content of an electronic health record (EHR)–generated after visit summary: a randomized clinical trial. J Am Board Fam Med 2014;27:209–18.
6. Scammon DL, Tabler J, Brunisholz K, et al. Organizational culture associated with provider satisfaction. J Am Board Fam Med 2014;27:219–28.
7. Willard-Grace R, Hessler D, Rogers E, Dubé K, Bodenheimer T, Grumbach K. Team structure and culture are associated with lower burnout in primary care. J Am Board Fam Med 2014;27:229–38.
8. Carvajal DN, Blank AE, Lechuga C, Schechter C, McKee MD. Do primary care patient experiences vary by teaching versus nonteaching facility? J Am Board Fam Med 2014;27:239–48.
9. Fenton JJ, Jerant AF, Franks P. Influence of Elective versus Emergent Hospital Admission on Patient Satisfaction. J Am Board Fam Med 2014;27:249–57.
10. Herman L, Froelich J, Kanelos D, et al. Utility of a genomic-based, personalized medicine test in patients presenting with symptoms suggesting coronary artery disease. J Am Board Fam Med 2014;27:258–67.
11. Skelton A, Kuhn C, Rothenberg D, Pope A. Older women's willingness to discontinue Papanicolaou test screening. J Am Board Fam Med 2014;27:295–6.
12. Hickner J, Thompson PJ, Wilkinson T, et al. Primary care physicians' challenges in ordering clinical laboratory tests and interpreting results. J Am Board Fam Med 2014;27:268–74.
13. Stewart TV, Loskutova N, Galliher JM, et al. Practice patterns, beliefs, and perceived barriers to care regarding dementia: a report from the American Academy of Family Physicians (AAFP) National Research Network. J Am Board Fam Med 2014;27:275–83.
14. Huffman MM, Mounsey A. Hepatitis C for primary care physicians. J Am Board Fam Med 2014;27:284–91.
15. Chauhan B, Panchal P, Szabo E, Wilkins T. Split peroneus brevis tendon: an unusual cause of ankle pain and instability. J Am Board Fam Med 2014;27:297–302.