EDITORS' NOTE

Data Supporting Key Components of Family Medicine—Scope, Continuity, Interprofessional Care, and More

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This issue contains multiple articles supporting key components of family medicine, either evidence that these components are important, or strategies to implement them in practice. For examples, see the articles on interprofessional care,[1–5] continuity,[6] cultural competence,[7] continuing competence,[8,9] and provision of essential care to the underserved.[10] We provide additional insight into how different physicians interpret similar data on older patients.[11] We have broad physician input into potential items to be considered in the national Choosing Wisely campaign, with many excellent interventions identified that should be performed less often.[12] However, choosing wisely for the United States population should also require adequate payment to encompass the breadth of what family physicians can and want to do to improve health for and with their patients.[13] All the articles relate to improving quality and cost of health care. (J Am Board Fam Med 2015;28:163–165.)

Sometimes the main reason for publishing articles is not to convince family physicians of some issue, but to convince other influential stakeholders of the problem. Such it is with the huge problem of providing the full scope of care that family physicians want to give and are expected to provide in patient-centered medical homes—payment/reimbursement/money available—whatever you want to call it, is totally inadequate to actually provide those services. Maximizing the benefit of broad-based care with goals focused on patient outcomes in family medicine while paid inadequately in widgets is untenable and unsustainable. We appreciate Ho[13] for documenting the extent of the underpayment—a whopping 80%.

Similarly, many of our published articles, reflecting the scope of family medicine, are important to other specialties as well. The article by Grad et al[12] is certainly one of these. The Choosing Wisely campaign has been wonderfully successful at calling attention to unnecessary testing and procedures, raising consciousness among patient and health care providers. Meanwhile, patient-oriented evidence that matters (POEM) is useful for identifying literature particularly helpful for evidence-based practice. Grad et al[12] cleverly identified that the process of choosing POEMs would identify tests or procedures that should be considered for the Choosing Wisely campaigns. One look at the list identified by POEM reviewers certainly verifies that more items need added to the Choosing Wisely campaign nationally, and we hope this article stimulates more physicians to stop/reduce performing unnecessary tests and procedures.

This issue continues our emphasis on using teams to improve care. "To achieve interprofessional collaboration, practice teams require structural supports that facilitate coordination of care and mutual respect." This is the obvious and expected conclusion from observation and interviews with exemplar practices that had high levels of interprofessional collaboration.[1] However, the novel part of the article is in the rich detail provided by the participants on how this was accomplished. Well worth reading and emulating. Liu et al[3] employed a lay navigator to help bring patients up to date for colon cancer screening. Their results can help others working to improve screening rates; of note, offering FIT testing as an alternative to colonoscopy increased uptake.

After initiating two concurrent interventions, that is, academic detailing and the offer of nurse triage to patients, Blackmore et al's[2] study identi-

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fied fewer unnecessary visits and decreased antibiotic use in a large study population with more than 50,000 visits for acute respiratory infection, resulting in health care dollar savings. Not all studies have found similar decreases in visits. Interestingly, the rate of decreased visits was still relatively small (<10%), suggesting additional room for improvement, if we could just decide on what it would take to make that happen. Certainly nurse triage and physician education would be places to start.

Two companion articles are included in this issue, one on implementing a tobacco use registry[4] and the other on an accompanying decision support tool.[5] The registry went beyond merely noting whether patients smoked or not, and included various actions and status related to tobacco use. The registry showed some positive influences that can lead to decreased tobacco use in the long term; as we know, smoking cessation often requires multiple attempts over years before success becomes permanent. The decision support tool was associated with health care provider confidence in prescribing the various medications to help patients with tobacco use, while not lengthening patient visit time. The office already had other decision support tools, so their use was not unusual. Consistent with the results in the Chen[1] article, specific tasks were assigned to the medical assistant, and others to the physicians or other provider, all documented in the electronic health record by a chronic disease manager.

Hospitalizations account for the majority of costs for chronic obstructive pulmonary disease (COPD). From Taiwan, Lin et al,[6] observed in a population of approximately 3000 that continuity of physician care was associated with substantially lower rates of hospitalizations for COPD. While continuity of care has been associated with other health outcomes, little is reported on the impact on hospitalizations specifically, and this provides welcome evidence for the core family medicine expectation of continuity.

Microaggressions are subtle, often unconscious forms of discrimination. Walls et al[7] report that Native Americans with diabetes who reported various microaggressions had poorer health. How can we as health care providers know when we are showing our cultural insensitivities—whether micro or not, intended or not—and improve?

At first blush, the Article from Van Kempen et al[11] can be confusing or seem unfamiliar to physicians from countries other than the Netherlands, but the main outcome is generalizable: physicians of different experiences often have different views of the same patient's ability. Hospital-based geriatric physicians were more likely to view the same elderly patients as more frail compared with outpatient-based family physicians. They agreed on frailty only about half the time. The family physicians had the advantages of continuity with the patients, and practice-associated nurse home visits. These types of systematic differences in assessment of frailty, surely based on physician experiences can, however, lead to differing views of recommended follow-up evaluation and treatment.

Is depression related to inadequate magnesium? Awareness of physiology suggests this is a plausible hypothesis for which there is already some support. Tarleton et al[14] explored this association using data from the National Health and Nutrition Examination surveys. Many Americans consume less than the recommended amount of dietary magnesium, yet there are questions about the reliability of magnesium levels. Magnesium intake is generally higher in an overall healthy diet. The results add to the confusion: the association with depression was stronger in younger but not older people, thus we need to dig deeper or wider.

Portable sleep monitors have been around for a while now, and their use has increased. Nickerson et al[10] looked at the feasibility of using portable sleep monitors in a particularly needy population, that is, those from a community health center who were nonwhite, at high risk for many health morbidities, and with many uninsured. Notably, all the patients returned the monitors, and approximately two thirds were eventually formally diagnosed with sleep apnea. This month, we also have an excellent review on the diagnosis and management of acute coronary syndromes, a constantly evolving area of high importance for family physicians.[15]

Family medicine encompasses many aspects of medicine, and thus the family medicine certification examination should appropriately reflect the broad scope of practice. Peterson et al[8] shows that the examination meets this objective. For example, physicians who do not see children are less likely to do well on the pediatrics portions of the examination. Because of a broader scope of care, particularly hospital medicine, rural physicians were substantially more likely to pass recertification exams. These results are consistent with the overall higher pass rate yet lower average scores of first-time ex-

amination takers.[9] During residency physicians are exposed to all aspects of family medicine whereas recertifying physicians may have limited their scope but know more from their years of experience seeing a cumulative greater number of patients. I (M.A.B.) know my patients have taught me much.

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