EDITORS' NOTE

Social Determinants of Health and Beyond: Information to Help Family Physicians Improve Patient Care

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Social determinants of health (SDOHs) are a theme in this issue. In addition, we include a series of clinical articles to inform family medicine. One helps to demystify the process of obtaining hearing care. Another provides a case report of how a vanishing twin can confuse a newly available test. We also share articles on the early symptoms and signs of femoral insufficiency fractures and a simple test to help diagnose basal cell carcinomas. Family physicians provide their views on point-of-care tests. Positive outcomes are reported for behavioral health integration into family medicine offices and for diabetes education among patients cared for within patient-centered medical homes. A questionnaire can help family physicians identify and facilitate conversations with their patients about adverse childhood experiences. (J Am Board Fam Med 2016;29:295–296.)

In this issue, the clinical review article on hearing loss[1] is wonderfully practical and answers many questions asked by patients and clinicians in family medicine offices. The system for obtaining appropriate hearing tests and hearing aids is certainly opaque to many people, and this guidance can help.

Femoral insufficiency fractures are uncommon but can be related to bisphosphonate therapy for the common diagnosis of osteoporosis. Based on a clinical case, Shaikh et al[2] provide a review of the often subtle symptoms and radiographic findings that suggest the possibility of an insufficiency fracture and thus prompt further evaluation.

In another clinical pearl, Quach et al[3] describe a clinical finding—the "basal cell blanche"—that can estimate the extent of a basal cell cancer and, to a certain extent, help clinicians determine whether a skin lesion might be a basal cell carcinoma. Some clinicians may have already figured out this practical hint, but if you have not, it is a quick and useful maneuver.

In a fascinating twist, the accuracy of a new prenatal test may be less than expected, creating potential uncertainty and anxiety for expecting parents and their clinicians. Vanished twins have long been known to happen, at least since the time of prenatal ultrasound. The new noninvasive test is cell-free DNA testing, which can determine the (presumed) sex of an infant with a simple maternal blood draw. Kelley[4] provides a case report describing an instance when this noninvasive blood test led to confusion at the time of the infant's birth, and therefore led to additional testing of the infant to verify the correct sex. This situation may be rare, but clinicians need to be aware, and families forewarned, of this possibility.

Family physicians use a large number of point-of-care tests in the office, and generally we can expect this trend to increase as technology makes accurate office testing more feasible. In general, this is good. Years ago, family physicians did far more testing in the office, providing patient convenience and helping office finances. In recent years, testing has shifted to their health system employers or outside corporations. In the article by Sohn et al.[5], primary care physicians rate what are, or could be, the most useful point-of-care tests.

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

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Increasingly, we learn of the benefits of the patient-centered medical home (PCMH) model. Manard et al[6] report on a system with primary care offices, some of which were PCMH designated and some of which were not. Patients from the PCMH office with prediabetes or diabetes were more likely to receive diabetes education referrals. A strength of this study is the large sample size of ≥1000 patients with at least 2 visits for prediabetes or diabetes.

Several articles in this issue are about behavioral health in family medicine. Behavioral health collaboration and partnership is important in family medicine, and is considered key in the PCMH. As shown in the *JABFM* supplement on behavioral health integration,[7] it is not simple to successfully and efficiently incorporate behavioral clinicians into family medicine offices. In the study by van Eeghen et al,[8] all measures showed positive improvement after various office changes, some of which involved in-office behavioral health clinicians. Over 8000 patients were cared for in the outpatient office during the study period, with >700 behavioral health referrals. Although there was no measure of improvement in mental health, the increase in the number of patient visits with a behavioral clinician is a wonderful start.

Adverse childhood experiences are an example of situations that lead to the need for behavioral health interventions. These traumatic events are associated with long-term effects, often into adulthood. Glowa et al[9] report using a previsit childhood adverse experience questionnaire with adults visiting family physicians. The questionnaire results were provided to the physicians. The physicians reported changes in discussion or actions based on the questionnaire and noted an appreciation of the information, which was often new to them. For more on the integration of behavioral health in family medicine, see the articles related to the theme of social determinants of health in this issue, along with the associated commentary by Hughes et al.[10]

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