EDITORS' NOTE

In This Issue: Opiates, Tobacco, Social Determinants of Health, Social Accountability for Non-Profit Hospitals, More on PCMH, and Clinical Topics

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This issue contains several articles about the factors contributing to the complex and deadly interplay between social determinants of health, pain, mental illness, and addictive substances such as opioids and tobacco. One article clearly is a call to action: more than half of opioid prescriptions in the United States are given to patients with mental health problems. Two articles report work on the next steps for social determinants of health in health care settings. Social accountability based on community health needs assessments required of community hospitals should lead to the creation of more family medicine residency positions. Patient-centered medical home (PCMH) recognition can be costly. A new typology for PCMHs is proposed. Other topics include group advance care planning visits, the interaction of dental and primary care, free clinics, a fix for a squeaking wrist, adherence to latent tuberculosis treatment, and more. (J Am Board Fam Med 2017;30:399–401.)

Deadly Interactions

Let us start with frightening data from the US Medical Expenditure Panel Survey[1]: almost 1 in 5 Americans with mental health disorders receive a prescription for opioids. Worse, adults with mental health conditions receive *half* of the total opioid prescriptions distributed in the United States each year. What are we treating? Which comes first, mental illness, then pain, then opioids, then drug use? Or some other order? Further, how is opioid use related to social determinants of health?

Social determinants of health are known to dramatically affect health. There is a national push to improve health by screening for these determinants through health care systems, followed by appropriate intervention, such as referral to social services. Byoff et al[2] worked with 23 health centers in Michigan, reviewed the forms they use to screen for social determinants of health, and developed broad consensus on a core set of 13 domains that align with nationally recommended screening guidelines. In another project, Gold et al[3] worked with community health centers to develop electronic health record–based social determinants of health data tools, specifically to standardize documentation of social determinants of health and to create appropriate follow-up actions. This is a major undertaking with potential widespread implications, as many systems with various electronic health records are facing the same challenges.

A related scourge is tobacco smoking. e-Cigarette use has increased dramatically, and some patients and providers believe this modality can help people quit smoking cigarettes. Ofei-Dodoo et al[4] report that a majority of Kansas family physicians answering a survey did not recommend e-cigarettes to assist tobacco cessation, primarily related to concerns about insufficient evidence of safety and effectiveness. Some family physicians who do recommend e-cigarette use note positive experiences reported by some patients. Unfortunately, e-cigarettes are another product that has gained widespread use in the market before their potential long-term safety or side effects are known.

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

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Social Accountability and the Need for Family Physicians

Raffoul and Phillips[5] provide a gem of a Special Communication, with great potential importance. Using Texas as an example, and reviewing the community health needs assessments required of nonprofit hospitals, they point out that more hospitals should and could create new residency positions for family medicine in their required implementation plans. Certainly this should be a national priority; after all, it is fitting public accountability for nonprofit status. Our policy brief this month is also about the availability of family physicians to provide care—specifically obstetric care.[6]

Health Services and Practice Methods

Patient-centered medical homes (PCMHs) continue to attract attention as a means to improve care. Fleming et al[7] found substantial costs for individual practices to attain or renew National Committee for Quality Assurance Level III recognition, even when those practices are supported centrally through a large medical group's corporation and with a common electronic health record. The total incremental cost for initial recognition between the corporation and individual practice was estimated at around $43,000 per 5-physician practice. The question is, do the costs lead to sufficient improvements in care for PCMH patients? Or could we just, please, get sufficient reimbursement to hire more help? In a different consideration of PCMHs beyond the National Committee for Quality Assurance definitions, Kieber-Emmons and Miller[8] extracted data from all publications of the 59 PCMHs in the annual review by the Patient-Centered Primary Care Collaborative. The authors identified 4 PCMH types and 6 outcome categories. Only the "integrated" PCMH type was associated with improvements in all 6 outcome categories. This PCMH framing typology could be useful in the positive transformation of primary care.

Lum et al[9] identified that group visits for advance care planning for patients ≥65 years old at primary care offices are feasible and encourage documentation of care plans and a surrogate decision maker in the medical record. The next step is to be sure that the necessary conversations occur between the participants and their designated surrogates in order to ensure the patient's desires are understood and followed.

Most federally qualified community health centers have dental units. Maxey et al[10] qualitatively considered interaction between dental health and primary care physicians at 5 centers with dental units. Although all provided dental services, not all were colocated with the primary care physicians. Through interviews of staff, the researchers identified the roles of the primary care physicians in supporting dental care. We suspect many family physicians wish dentists were available in their offices, as we see much dental disease that does not seem to be managed. Shy of dentists in our offices, we would like dentists who will accept and see our patients in a timely fashion.

Sanders et al[11] sought to determine whether a local free chronic disease management clinic in community settings would save dollars for a health system. In other words, could this clinic generate net savings, equivalent to a profit? Using quality adjusted life-years and return-on-investment techniques, the cost-savings over 6 years were modest and less than the expenses. Lee et al[12] demonstrate that energetic medical students who work hard can make a big difference in a student-run clinic; we need these students helping the practice of family medicine for the long run. Consistent with our national angst and concerns about the future of health care, Gordon[13] took a cross-country bicycling sabbatical and listened to many Americans' views on Obamacare. May his reflections help us all be stronger.

Clinical Treatment

Many family physicians oversee treatment for latent tuberculosis, which is important to prevent active, infectious tuberculosis. Using a retrospective review methodology of 3 accepted medication regimens, Eastment et al[14] revealed that patients who received the shorter durations of treatment (3 or 4 months) were more likely to complete treatment than those receiving the longest treatment regimen (9 months). This review included several different treatment sites, and some of the patients were given monetary incentives to take the medicine or received free medication. Other common factors associated with nonadherence were not as important as the many additional months needed to complete the isoniazid-only treatment course, which is often the least expensive treatment and thus attractive to funders—in this case a bad trade-off.

Through a concurrent survey and many chart reviews in academic family medicine practices, Ie et

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al[15] found that prioritizing the number and benefit-to-risk ratio of medicines was associated with a lower number of prescribed medicines, and a lower number of potentially inappropriate medications, for older patients. These prescribing patterns did not vary by years of experience, which suggest physicians have long-held beliefs, which are often not easy to change. This points to the need to teach this approach to medication prescribing early in a physician's medical career.

A couple of informative case reports of interest are included in this issue. First, Skinner et al[16] presents what is called "intersection syndrome," which has a rare symptom—wrist "squeaking"—and provides visuals on how to fix this in the office. Quite a combination! Next, Kewish[17] presents a case report on herpes zoster after auricular acupuncture, which is widely used and quite safe. That sufficient, albeit minor, trauma could precipitate shingles is not a surprise but is thankfully uncommon.

Owens and Oliphant[18] highlight the occurrence of angioedema with the new drug category of neprilysin inhibitors, specifically the combination of sacubitril and valsartan for heart failure. Neprilysin inhibitors work by increasing the bioavailability of natriuretic peptides, bradykinin, and substance P, which results in natriuresis and vasodilation. Overall, the hope was that the combination of sacubitril with valsartan would result in a low rate of angioedema while further improving heart failure, in comparison to enalapril. The authors note there was still significant angioedema with sacubitril/valsartan, a rate that seemed to be higher in black patients, so use caution, particularly in patients with a history of angioedema.

Next issue: Look for our annual theme issue on practice-based research and reports from practice-based research networks!

To see this article online, please go to: http://jabfm.org/content/30/4/399.full.

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