EDITORS' NOTE

Multiple Practical Facts and Ideas to Improve Family Medicine Care

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Seconds count in a study on the best electronic health note format to reduce medical record charting time and increase accuracy. Directly observed family physician work is compared with Current Procedural Terminology (CPT) coding examples and notably under-recognized. This issue contains articles from single practices that that implemented new methods of care and other reports on practice innovations that can be more broadly implemented. We have articles on opioid medication use for acute low back pain in primary care, an electronic chronic pain consult service, a key question to identify potential opioid misuse risk, and newly implemented screening for other substances of abuse. Omissions (or gaps) in care are also highlighted: from the common types of omissions identified by primary care clinicians, self-reported low levels of substance use screening by family medicine prenatal care providers, and inadequate and inadequately available hospital discharge summaries. In addition, the most important alarm symptoms for a cancer diagnosis are reported. (J Am Board Fam Med 2017;30:687–690.)

Seconds Count—How to Improve Electronic Health Records, and Thus Physicians' Lives

In the category of useful and practical, and some potential relief from the electronic health record (EHR) frustrations blamed for physician burnout, Belden et al[1] compared different EHR note formats (including some novel prototypes) by several excellent methods (audio, computer-screen activity, eye tracking, and field notes). The authors measured the actual time-on-task, as well as accuracy and effort. A reminder is that the few seconds' difference between the formats can add up quickly across many charts and visits. Some notes were collapsible in design. The proposed note prototypes performed better than the traditional Subjective, Objective, Assessment, Plan (SOAP) note format for speed, accuracy, and usability. It is worth looking at the appendices to see the actual note formats.[1] Here's to having many individuals show this article to their EHR vendor!

Care Innovation Reports from Single Family Medicine Offices

In our lead article, Schwartz et al[2] discusses incorporating pharmacogenetics into a family practice for making medication decisions. A pharmacist completed medication reconciliation with patients taking a large number of medications and reviewed the completed pharmacogenetic testing, then made recommendations to the physician for medication changes. Drug-gene interactions were found a quarter of the time. In practice, I (MAB) have received pharmacogenetic reports ordered by psychiatrists for patients who have tried many different antidepressants without sufficient success. The reports seem to be useful for medication selection, but the full outcomes of pharmacogenetics on patient care are far from known. Axten et al[3] report on a novel wellness group visit model for obesity. A single family physician and collaborating dietician report on the success of this model, finding that much of the weight loss was sustained through 3 years of followup. See their excellent helpful hints for others willing to emulate.

Direct Observation of CPT Code Inadequacies and their Examples in Family Medicine

Young et al[4] directly observed family physicians at work and found that Current Procedural Terminology (CPT) code examples and implementation undervalue many important activities and effort. CPT examples do not provide increasing code levels for the common situation of many diagnoses. There are no examples explicitly for more than 3

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chronic stable disease diagnoses. The 99215 CPT code examples overemphasize serious diagnoses and testing that are uncommon in primary care. Time-based codes can be used for visits with >50% counseling, but undervalue physician time and effort. Overall, much of the observed physician effort cannot be coded at a level to equal their effort. As a reminder, the code examples and code systems do not directly determine physician reimbursement, which is determined through contracts and the entities paying for the care. And insurer policies can make a big difference. Overall, insurers could go over and beyond the CPT code examples in determining reimbursement for family medicine, and we think they should do so. Change CPT codes and examples, and increase the reimbursement for important family medicine activities!

Commissions, Omissions, and Inadequate Information for Optimal Primary Care

Gastala et al[5] took great advantage of data from Medicare Part D to consider some characteristics of physicians who prescribed a more expensive (higher cost to patient), compared with a less expensive (lower cost to patient) equivalent drug, that is, what are the characteristics of the physicians who were the better stewards of patients' and Medicare dollars? In this report of esomeprazole (higher cost) or omeprazole (lower cost), the difference to the patient was 10-fold. It is reassuring to see that the odds of being better stewards were higher if the physicians participated in a Patient-Centered Medical Home or worked with a care coordinator, as the family medicine profession has worked diligently to incorporate these concepts into our practices. These authors also report other interesting factors including sex of the physician and geography.

Poghosyan et al[6] found that the most common types of omission of care noted by primary care clinicians were those less readily identified through chart or EHR review, or take more visit time, and are under-reimbursed, that is, patient teaching and emotional support. Who is surprised? Academic family physicians providing obstetric care report concerns about the use of nicotine (in various forms) and marijuana during pregnancy; albeit most do not screen consistently for these substances.[7]

Robelia et al[8] reports that the hospital discharge summary is still failing; despite all the electronic records and readily available methods for rapid information transfer, the receiving family physician often still is not provided key discharge information. Having access to the inpatient record helped with the insufficiency of information, but it seems like digging through a hospital record could take much more time than receiving a complete, organized, direct summary of the record. How can this be fixed?

A New Type of Pain Consult Service, Opioids Used for Low Back Pain, and Screening for Cannabis Use

Liddy et al[9] reports on a confidential Canadian electronic consult service designed to support primary care clinicians treating patients with chronic pain. The primary care clinicians submitted concerns through an electronic link, and a pain specialist sent back information and provided sympathy and encouragement, sometimes over several exchanges. Multiple types of issues and helpful suggestions are provided in the article. The primary care clinicians rated the service highly, and this type of support could empower more physicians to treat significant chronic pain.

Opioid treatments are receiving lots of attention. We provide 2 articles on use of opioid medication for acute low back pain in primary care. Gebauer et al[10] studied the use of opiate medications in adults with new-onset back pain in relationship to socioeconomic status. Patients living in lower socioeconomic areas were 2 thirds more likely to receive a prescription for an opioid medication only, rather than in conjunction with other treatments. These same individuals also had a higher rate of smoking, more comorbidity, and higher clinic utilization. In the Thackeray et al[11] article, Medicaid patients with new acute low back pain who received a physical therapy consult only, or who participated in physical therapy, had a third less chance of an opioid prescription in the following year. Of note, both articles found that physical therapy referral was positively associated with non-opioid prescriptions, and those with higher comorbidities and tobacco use were less likely to receive a physical therapy consult. It is unclear how copayments for physical therapy may have influenced these findings.

In a third article about opioid medications in primary care, Lutz et al[12] found that a single ques-

tion can predict risk of opioid misuse, explaining approximately 30% of the variance (and that is a lot!). Can you guess what it is? Once you read the answer, it becomes quite easy to understand how patient belief is so important to misuse potential. Hint: "catastrophizing" is key. Finally, a case report in this issue is designed to grab the attention of those clinicians unaware of the current widespread use of loperamide by opioid addicts to treat withdrawal symptoms, sometimes to disastrous effect. Vithalani et al[13] report that major dysrhythmias can result.

Opioid medications are not the only controlled substance issues of concern in primary care. Lapham et al[14] report on the frequency of admitted cannabis use in a primary care office and finds use was higher in younger men and associated with mental health disorders and smoking. Of note, this article is from Kaiser Permanente Washington, which is implementing routine questions on marijuana use as part of behavioral health screening for primary care patients. These authors also provide a useful listing of 11 criteria for cannabis use disorder.

Alarm Symptoms for Cancer and Difficulties Discussing Life Expectancy

Using 10 years of data from patient records in The Netherlands, van Boven et al[15] investigated the relationship of alarm symptoms stated as the chief complaint for adult primary care visits to the final diagnosis of cancer. The most important alarm symptoms should not be a surprise: for example, a chief complaint of a breast lump had a positive predictive value of 15% for breast cancer. Other common alarm symptoms had lower but important positive predictive values, helping to reinforce which chief complaints should be particularly concerning and followed up accordingly.

Schoenborn et al[16] report that people can be uncomfortable discussing life expectancy, even when seriously ill. Community-dwelling older adults reported that an obvious health decline was a good trigger for a life expectancy discussion with their physician, and some were interested in having physicians discuss life expectancy with family members before talking to them individually. The patients also said it was acceptable for the physician to bring up the subject of life expectancy, and then follow the patient's lead on the extent of the discussion.

In another interesting case report, Low et al[17] provide us with a "first": a report of using cervical traction for a patient's refractory "notalgia anesthetica" (a name derived from Greek terminology). Thankfully, this therapy was successful after many treatment failures and years of discomfort. Although an uncommon problem, this practical treatment can make the family doctor look like a star.

National Data with Implications for Future Health Care

Perhaps the article by Peabody et al[18] should be called, "The DO's are Coming!" The new single Graduate Medical Education accreditation system for both allopathic and osteopathic physicians, along with the rapid expansion of osteopathic medical schools will change the future of the US family medicine workforce. So, more doctors, but not necessarily better access to care for rural Americans—Villapiano et al[19] report on the concurrently growing urban-rural gap for hospital mortality.

Global as Local

Ramírez Aranda et al[20] discuss health care reform in Mexico. Although the United States struggles with the balance of specialties, Mexico has it worse—apparently, there is little role for primary care in its health care reform. Ramirez-Aranda et al[20] summarize their group's thoughts and actions. This is an interesting article and remind us of the steps that all countries—especially the US—may need to take to avoid drifting away from basic health care needs. We wish our colleagues in Mexico much success.

To see this article online, please go to: http://jabfm.org/content/30/6/687.full.

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