EDITORS' NOTE

Interventions Must Be Realistic to Be Useful and Completed in Family Medicine

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Being realistic while helping our patients is this issue's theme. Given the volume of tasks required in family medicine, recommendations for improvements in direct care or care measurement cannot just be evidence-based but must also be realistic. On the list of realistic: ordering antipsychotics for symptoms of dementia in the elderly, despite recommendations to not do so; ordering antidepressants without fear that the patient could develop hypertension; mental health care providers in primary care offices; forced choice for opioid management; plus agenda setting for visit efficiency. Not yet realistic: trigger tools to identify adverse events, and pharmacist recommendations related to pain management before opioid visits. Pneumococcal vaccine compliance is only realistic if recommendations are not recurrently changed, are paid for, and if prior immunizations are known. Increasing task delegation to prevent clinician burnout is not realistic if it burns out the nurses, or if the helpful scribes cannot be afforded. Helpful, yet questionably realistic: Primary care clinician involvement for patients in intensive care units and their families, and problem-solving therapy by family physicians. And, let us add 'frightening': few international medical school graduates to serve the underserved. The most frequent diagnoses and most critical diagnoses in family medicine are elucidated. (J Am Board Fam Med 2018;31:1–4.)

In this issue we group articles into general categories based on our assessment of how realistic the implied actions are, related to current provider training, finances, and organizational factors.

Realistic

Many guidelines and the Centers for Medicare and Medicaid Services recommend against the use of antipsychotic medications for the symptoms of dementia, yet they are widely used. Kerns et al[1] document the important issues to explain this phenomena as noted by family physicians and general internists. One word could summarize their answer: "practical." Because the alternatives are not easily accomplished and are under-reimbursed, and the antipsychotics in low doses are relatively easily to use and seem to help without causing substantial harm in the patients in their practices, antipsychotics were considered, above all, practical. In the home or in the nursing home, it is not easy to do what is required to avoid the use of these medications.

Negative studies are as important as positive studies, as in the article by Breeden et al.[2] There are reports of high blood pressure occurring with antidepressants, some more than others, and some drugs have information to that effect in their package insert warnings. Data from a primary care clinical network, including >6,000 adult patients without hypertension who initiated antidepressant therapy, found no evidence of hypertension being induced, regardless of the specific antidepressant, after controlling for other risk factors (including neighborhood socioeconomic status). Given the difficulties we have in finding the right antidepressants for patients, this negative study can reassure us that we should choose the right antidepressants with little concern that we may be inducing hypertension.

Patients and physicians can list a large number of factors that inhibit efficient family medicine office visits.[3] The most important efficiency item identified in this qualitative study of patient and clinician interviews was setting the agenda at the beginning of the visit. Most clinicians learn this through training or trial and error, but backsliding into nonagenda setting seems common. It is worth reading the comments to think through how to

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improve your own efficiency, and to review the novel conceptual model.

Leung et al[4] retrospectively report on the changes in specialty mental health visits for >66,000 patients after embedding more mental health services into primary care, as required by the Veterans Administration since 2007. These nonphysician providers emphasize treating depression, anxiety, post-traumatic stress disorder, and alcohol misuse. After 5 years, the number of patients receiving mental health visits in primary care increased more than the number in specialty clinics decreased, indicating increased access to mental health services. No changes were identified in overall health care cost or mortality.

Helpful, but Realistic? Things to Do if You Can

Sattler et al[5] investigate one of the potential answers to the ongoing dilemma of too much to do, with too many expectations in family medicine leading to potential burnout, that is, medical scribes. Over 1 year, physicians with scribe assistance wrote short reflections on the experience. The quotes are interesting and informative for those considering their use. Scribes do things other than 'scribe' that can be useful, such as form completion, thus increasing efficiency. I (MAB) would note that there can be inefficiencies if the electronic health record does not allow more than 1 provider in the chart at the same time—the doctor cannot be looking at past laboratory values while the scribe is in the chart, nor write orders while the scribe writes the narrative portion. We do not yet know the best use of scribe talent, the full extent of scribe capabilities, nor the sustainable source of financial support. The reflections in this article indicate some possible tasks over and beyond the typical for the scribes, areas that need reflection and consideration for their roles, required education, and value.

McCann et al[6] provide the experience in 1 private family medicine practice of using a planned forced choice for ongoing use of opioids for chronic nonmalignant pain. The forced choice was to explicitly accept the new office plan by which the opioid care would be managed, or leave the practice. Probably many physicians have used 'forced-choice' for individual patients, but not in a preplanned and uniform manner where 1 of the choices was explicit departure from the practice. The results are informative and encouraging, as headway was made. The question of realism relates to the specific program put in place and how readily other offices could do the same.

Family physicians involvement in inpatient admissions is diminishing, particularly in intensive care units, which have moved to nonopen attending physician models with all patients cared for by intensivists. Hwang et al[7] provide evidence that primary care physician involvement in the shared decision making in a neurological intensive care unit was associated with patient families reporting higher satisfaction with their personal sense of control and involvement with decision making, that is, improved and patient- and family-centered care. We surmise these particular areas of increased satisfaction could have enduring effects on those same family members after discharge. There were no differences in other types of satisfaction. This study is an example of researchers outside of the field of family medicine seeking to assess the impact of our care.

E-cigarette use has increased markedly, providing a new legal avenue for potential tobacco abuse and addiction. Doescher et al[8] found one-third of patients in a family medicine office reported some e-cigarette use. Most of those reporting use desired a discussion with their clinician about e-cigarettes. Unfortunately, it would probably be better to discuss before, rather than after, they have started. Another check-box item for our list of potentially important office interactions, yet could this be accomplished with good regularity?

Zhang et al[9] provides insight into a helpful type of mental health care that is evidence-based and can be done in primary care and by family physicians, that is, problem-solving therapy. Advantages of this therapy is that it is short-term and can be delivered individually or in group settings. Furthermore, a manual outlines the treatment formula in detail, making it easier to learn and use. There is even a self-help manual available for patients. This systematic review and meta-analysis verifies success for physician-involved treatment for depression, albeit the improvement was less than that achieved by mental health providers.

Not Realistic

It is not realistic to trade off nurse versus clinician burnout through task delegation. One of the VA

initiatives in primary care is called Patient Aligned Care Teams (PACTs). Using a nationwide survey, Edwards et al[10] evaluate the relationship of task delegation to burnout. The results indicate that more delegation from clinicians to nurses essentially shifts their burnout to the nurses—the primary care providers (physicians, physician assistants or nurse practitioners) who delegated more were less burned out but their delegate nurses were more burned out. These results were not early in the implementation of PACTs, but 4 years later. In additional interest, all nurses reported substantial delegation to them for all task areas, whereas the clinicians reported greater variability in delegation by task area, that is, the nurses felt more was delegated to them than did the clinicians. As expected, inadequate staffing was also associated with burnout. We must consider the system as a whole, not just its parts.

High levels of vaccine implementation are unrealistic if there are too many inhibitors, as is the case of the pneumococcal vaccine. Family physicians believe in the pneumococcal vaccine and want to administer it correctly but only half found the current recommendations to be 'clear.'[11] Physician vaccine knowledge for patients over age 65 was high, but less so for younger patients. One could argue that computers can provide the correct orders, but the lack of adult immunization registries, cost, lack of insurance coverage, and inadequate reimbursement will still inhibit full implementation. These factors are outside the control of the primary care office. Perhaps the governmental entities who create the recommendations should be required to ensure the factors that facilitate success or directly consider feasibility before making vaccine recommendations. Otherwise, fewer patients get immunized.

Pharmacist review for outpatient opioid management seems to require too much effort to be realistic. Cox et al[12] report on a study in which pharmacists performed chart reviews and gave recommendations for the provider before the office visit for patients on over 50 morphine milligram equivalents (MME) of opioids per day. In a before-after review, the mean MME decreased 14% with no change in pain scores. Various other measures improved as well. Unfortunately, this required 'extensive pharmacist resources' that are not likely easily replicated. However, this gives one more avenue to help with diverse and difficult opioid addiction problems, and physicians can tell their patients who in many cases, doses *can* be reduced without affecting average pain scores.

The evidence is still out on trigger tools for adverse event (AE) identification, and thus they are not yet realistic. A 'negative' study in this issue is the article by Davis et al[13] on the Institute for Health care Improvement's (IHI) Outpatient Adverse Event Trigger Tool (IHI Tool). After searching more than 6,000 articles, 15 met eligibility criteria, 9 of which were conducted in the United States, 12 were retrospective, most were done at 1 site only, and only 4 were rated as "good" quality. Trigger tools are designed to help identify the patients whose charts should be reviewed for potential AEs; otherwise many AEs are not easily identified or analyzed to improve future AE prevention. None of the studies used all the IHI triggers. Many of the triggers had very low positive predictive values. It is noted that most adverse drug events were not prescribing or dispensing errors, yet medications are major sources of AEs. Of interest, agreement on the presence of an AE is higher than agreement on preventability or causation. As the authors state, "accurate trigger tools remain elusive."

Beyond Unrealistic, Even Frightening

International medical graduates serve a disproportionately high number of the patients otherwise underserved in the United States, both in urban and rural areas. Douaiher et al[14] explore current data and the discomforting implications of proposed changes. Immigrant physicians provide approximately one-quarter of the care to the underserved in the U.S, and in some rural counties, comprise as many as half of practicing primary care physicians. Of note, most of the international physicians admitted to the United States train in residencies of the 3 primary care specialties, that is, family medicine, internal medicine, or pediatrics. Using Association of American Medical Colleges data and projections of physician workforce needs, and considering current immigration policy, the authors explore the potential impacts. The number of US medical school graduates will not be sufficient to fill the number of available residency training positions for many years to come. Current proposals to limit immigration will reduce future access to care to the underserved, a trend going in the wrong direction.

What is the Breadth and Depth of Family Medicine Practice?

The information in the Peabody et al article[15] was collated and assisted by the American Board of Family Medicine (ABFM) certification examination categorizes, and is useful in understanding the content and domain of family medicine. For most family physicians in practice, the diagnoses lists will mirror their everyday practice experiences, and define the breadth (common) or depth (most critical diagnosis) that most represent family medicine. However, it should also cue individuals to understand the most frequently seen diagnoses, along with what would be expected for them to know to best serve their patients. The most common diagnoses were high blood pressure, diabetes mellitus, routine general medical examination, anxiety disorder (unspecified), other malaise and fatigue, and upper respiratory infection (and related acute respiratory infections), and asthma.

Other

Our clinical review this issue is on idiopathic pulmonary fibrosis.[16] From the family physician perspective, the original diagnosis is often the quandary—when is it pulmonary fibrosis with its poor prognosis, and when is it something else that is more currently treatable, and which treatment should be used? Salvatore et al[16] provide a helpful review of current diagnosis and treatment. A reader also provides us a letter about the importance of being an ABFM diplomate.

To see this article online, please go to: http://jabfm.org/content/31/1/1.full.

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