

**EDITORS' NOTE**

# Family Medicine: Data Driven Practice with Emphasis on Underserved Patients

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**Family physicians' role and interest in caring for underserved or undertreated patients is quite evident in this issue of JABFM. One in 5 family physicians provide urgent or emergency care, which is particularly important in rural areas. Methods and resources for obtaining information about social determinants of health are variable. A data-rich article considers how family medicine practice ownership might be associated with quality outcomes. We have articles on using text messages to increase HIV testing and colon cancer screening for Latino patients. For patients with significant behavioral health disorders, 1 article considers early posthospital follow-up to prevent readmission and another notes differences between the views of generalist physicians and psychiatrists on which specialty should test and manage antipsychotic-related metabolic disorders. Five articles provide topic-specific perspectives for diagnosis of systolic heart failure with preserved systolic function, primary care outpatient radiographs, polypharmacy in the elderly with dementia, supporting patients in self-management, and patient and family physician challenges in opioid prescribing. Furthermore, what happened to total opioid prescriptions when 1 version of opioid medication became more difficult to prescribe? Two articles provide treatment information for hepatitis C and initiation of basal insulin for diabetes. (J Am Board Fam Med 2019;32: 285–287.)**

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## Care of Underserved Patients

Caring for the underserved is common in family medicine. For example, 21% family physicians practice at least a portion of their time in an emergency department or urgent care setting, particularly in rural and frontier environments.<sup>1</sup>

Community health centers in Boston collect pediatric patient information on social determinants of health. To aid future efforts, Byoff et al<sup>2</sup> undertook a mixed methods evaluation of the various implementation methods. Each site had its own mix of issues, such as in staffing and patient flow, making a set standard or version for screening less likely.

Latino patients are less likely to get colon cancer screening. Thompson and coauthors<sup>3</sup> held structured sessions with Latino patients to identify potential messaging to increase colon cancer screening. Using the developed verbiage for reminders, Coronado et al<sup>4</sup> compared uptake of fecal immu-

nochemical testing (FIT) for colorectal cancer by types of patient reminders, including texting. Wettermann et al<sup>5</sup> also used texting to increase HIV testing among underserved patients.

Patient self-management support is empowering and can improve outcomes. Primary care clinicians and their practices vary substantially on the level of self-management support reported. Jotberg et al<sup>6</sup> provided information on practice characteristics that are associated with greater self-management support, including rural location, higher percentage of poor or underserved patients, and patient-centered medical home. The results further suggest specific practices that could improve patient outcomes.

Two articles related to patients with significant behavioral health conditions. The research of Pourat et al<sup>7</sup> added to the literature on the effect of posthospitalization follow-up visits on the chances of rehospitalization by specifically considering those patients with behavioral health conditions. There are other additional findings of interest that provide hints to improve hospitalization follow-up.

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Mangurian et al<sup>8</sup> found a major disconnect in care for patients taking antipsychotic drugs that have common associated life-threatening metabolic side effects. Primary care clinicians and psychiatrists disagree on which clinician should test for and/or treat these side effects. This disconnect is even more likely to create issues when the patient's medical record is not available to both types of specialists, as is common. The clinician editors believe the testing could be undertaken by either specialty, but the primary care clinician should undertake the medical care of the metabolic abnormalities, as the care quickly becomes complicated beyond a typical psychiatrists' scope of care.

### Opioid Prescribing

In 2014, the US Drug Enforcement Agency changed hydrocodone-combination analgesics from Schedule III to Schedule II to discourage the prescribing of these analgesics, as Schedule II drugs cannot be refilled. Logically, this should help with the "Opioid epidemic." Did it? Northrup and fellow authors<sup>9</sup> looked at what happened in a group of safety-net offices. The authors specifically included tramadol, a Schedule IV drug often excluded from other studies, and further provided new information by considering postrescheduling medication prescription change probabilities by patient diagnoses, patient characteristics, and medical specialties. The positive result was that hydrocodone-combination analgesics did drop dramatically. However, tramadol and codeine combinations increased significantly, with the number of patients receiving 1 or another opioid overall increasing—definitely not the intended direction of scheduling changes. The cause and effect relationship is unknown.

Satterwhite et al<sup>10</sup> used several methods to consider issues in undertaking appropriate prescribing and care for patients on chronic opioids in safety-net settings. The separate comments made by physicians and patients indicate clear concurrence that doing it well takes more time than is available in primary care schedules.

### Perspectives on Other Clinical Issues

Sometimes the field of medicine can get quite caught up in definitions and, mostly, rightfully so. However, family physicians are commonly faced with the vagaries of specific illness diagnosis. Thus,

the treatise on systolic heart failure with preserved systolic function<sup>11</sup> is of interest. Do we actually know what this entity is and does making the specific diagnosis change treatment?

Greene et al<sup>12</sup> explored the many difficulties physicians face on the subject of polypharmacy in elderly patients with dementia; obviously more information is needed on what can or should be done for these patients.

Ambulatory radiographs are perceived to be overused. Suchsland et al<sup>13</sup> explored how primary care providers think about the patient perspectives of the outcomes, the advantages, and the disadvantages of ordering these tests. The authors offered suggestions on what could assist appropriate ordering.

The article by Lindner et al<sup>14</sup> is a trove of fascinating data by ownership of family medicine practices, including patient mix, stability, and location, over and beyond the measures suggested in the title. On the major topic of quality, the authors found only 1 difference in the patient-care outcomes as documented in the charts, specifically that physician-owned practices had less smoking cessation counseling documentation. This could be an issue of documentation rather than clinician action. The data also showed marked differences between practice ownership types and the infrastructure available to support quality improvement.

### Clinical How-To's: Basal Insulin for Diabetes and Treatment of Hepatitis C

A clinical review by Perreault et al<sup>15</sup> on basal insulin treatment for diabetes provided many practical ideas to decide how and what basal insulin to use, as well as items to help patients understand their treatment. Over a few years, there have been modest increases in patient understanding of the term body mass index and the potential consequences of obesity,<sup>16</sup> but that does not mean that their clinicians discussed obesity with them. Simoncini and coauthors<sup>17</sup> provided information to support the treatment of hepatitis C by primary care physicians.

*To see this article online, please go to: <http://jabfm.org/content/32/3/285.full>.*

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