EDITORS' NOTE

Medications, Medicating, and Medicated—When, Where, and How—Opioids and Others

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Medication therapy emerged as a theme for this issue—from many perspectives and for different conditions. We have several articles on opioids, including for pain/noncancer pain; use by older drivers and their reported driving; and the advantages of family medicine treatment sites. A related article explores chronic widespread pain and concurrent low back pain. In addition, this issue covers the gamut of prescribing inappropriate medications for older individuals and prescribing antibiotics when a CT scan of the abdomen would not have found an indication for such treatment. Other included topics include social complexity and impact on primary care physician income. (J Am Board Fam Med 2020;33:489–490.)

More on Opioid Medication and Pain

Patients needing opioid use disorder treatment value accessibility and confidentiality, which makes family medicine a most attractive treatment venue.[1] Multiple other positives were also noted by the patients. Stack and colleagues[2] provide detailed information on their successful rural family practice intervention to reduce opioid dose levels by patient with chronic noncancer pain. They provide details of their plan, and repeated a successful similar intervention in a second practice. In addition, readers may benefit from the experiences and suggestions from the offices that participated in the qualitative study by Brooke and Tong[3] across 30 practices subsequent to Virginia's initiation of a new benefit for outpatient medication assisted therapy.

Of course, avoidance of narcotics is preferable. A small (but concerning) minority of older adults (ages 65 to 79 years) self-report concurrent opioid medication use and driving, and some also admit to impaired driving and self-regulated driving reductions.[4] Scary. Interestingly, these driving concerns were in those who also reported more significant medical conditions. There is little evidence base for clinical decision support systems for the use of narcotics for chronic noncancer pain.[5] Hopefully 1 or more *JABFM* readers will take up this research challenge.

Licciardone and Pandya[6] put words to a phenomenon that family physicians will recognize: many patients with chronic low back pain also have intermittent or chronic widespread pain, sometimes with concurrent catastrophizing. These data come from a patient registry, three fourths of whom were women.

More on Prescribing

In a large health plan population, patients with irritable bowel syndrome were substantially more likely than others to be diagnosed with diverticulitis and treated with antibiotics without undergoing a CT scan, suggesting overdiagnosis.[7] One takeaway could be to consider a CT scan *before* deciding antibiotics are the best choice.

Using data from Medicare Part D, Jabbarpour et al[8] found that the rate of potentially inappropriate medication prescribing for older patients by primary care physicians ranged from about 1% (bottom quartile) to 10% (top quartile). Gender and specialty of the physician were significant associations with rates of prescribing less appropriate medication.

Nonindicated Vitamin D testing can lead to a cascade of (expensive) testing and/or prescriptions, with unclear results,[9] and that analysis did not include new intake of over-the-counter Vitamin D. We recommend readers look at their thought-provoking Figure 1 as it visually captures the cascade that occurred over the 2-year study period.

Increasing Access

Relative to those with employer-sponsored health insurance, adults with Medicaid insurance perceived more discrimination due to race of skin color (regardless of their own race).[10]

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

The rate of HPV vaccination for men has gradually been increasing but is far from ideal. Primary care physicians and regular checkups are particularly important to further improving uptake.[11]

Venkataramani et al[12] suggest considering a new way to promote postdelivery follow-up care for women with gestational diabetes. Family physicians are familiar with using the infant's visit to check on the mother's followup, but many babies see pediatricians. However, many mothers interact regularly with social services WIC (Special Supplemental Nutrition Program for Women, Infants, and Children) and Headstart, thus suggesting new places to increase screening.

Cotrell et al[13] quantify an interaction that is understood clinically, but underrecognized by current care reimbursement systems that rely on quality measurements. Namely, poor control of diabetes is substantially associated with social complexity. If this relationship was adequately taken into account, some physicians would have better quality scores, and higher reimbursement.

Covering yet more territory of classic family medicine, this issue includes a clinical review of atopic dermatitis.[14] And, as typical, this article likely includes at least 1 or more facts that the practicing family physician may not have considered or recognized previously. For M Bowman (author), it was particularly the newer medications used for severe atopic dermatitis (Table 2).

In what areas do you think small practices excel? Parchman et al[15] studied reporting quality measures by primary care practices with and without central support and found that small practices do well at quality improvement reporting. Family physicians are increasingly working with multiple types of nonphysician providers, indicating more "team provision" of care.[16]

To see this article online, please go to: http://jabfm.org/content/33/489.full.

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