EDITORS' NOTE

Clinical and Practice Innovation Improving the Practice of Family Medicine

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Quite a lineup showcasing JABFM's emphasis on research and information for family medicine to improve patients' lives. Articles cover many topics: telemedicine, a clinical decision support tool, control of cardiovascular risk factors, opioid dose reduction, cancer survivorship care, patient engagement with case management/navigation, primary care physician capacity and usual source of care, marketing practices of Medicare Advantage programs, review articles (new diabetes medicine and treatment CHF with reduced ejection fraction), and more. (J Am Board Fam Med 2024;37:357–359.)

Patient Management and Support

Heart failure and diabetes are common diagnoses in family medicine practices. Williamson and Tong[1] review the treatment of a subtype, specifically heart failure with reduced ejection fraction. Morrison et al[2] review new medications for diabetes [glucagon-like peptide-1 receptor agonists (GLP-1 RAs) and sodium glucose cotransporter-2 inhibitors (SGLT2-Is)], including cardiovascular and renal effects.

Controlled substances are often needed but can generate other problems. Sanders et al[3] describe a cohort-based study within a family practice. Results generate evidence for the use of controlled substance safety committees (CSSC) to decrease the use of opioids, including as examined through the lens of health equity. Hooker et al[4] suggest that Clinical Decision Support (CDS) tools can also support management of opioid use. CDS tools are designed to help primary care clinicians implement evidence-based guidelines for chronic disease care. Dr. Hemler et al[5] report on innovations in survivorship care for primary care. Opioids are sometimes necessary, but the goal is to only use them when truly needed.

Another study[6] describes telemedicine use among primary care clinicians in safety net settings, including variation in telemedicine modalities used and impact on access. This survey, fielded between September 2020 and April 2023, found that though safety net providers were more likely to report barriers to telemedicine use (eg, lack of broadband), they were also more likely to report telemedicine reduced no-shows and potentially improved access to care.

There is disappointing news in an article describing the proportion of patients who accept health and social needs case management initiated by practices.[7] How much is due to how case managers contact patients, competing demands in patients' lives, or other patient concerns? Despite the limitations, it seems that clinicians assist with these issues,[8] as community health center clinicians described routinely adjusting patient care plans based on their patients' social contexts. Somewhat in contrast, Aronstam et al[9] report on caregivers' description of 3 pathways through which a navigation program reportedly affected overall child and/or caregiver health, including increasing knowledge, connection, and emotional support. Participants suggested that navigation programs can influence health even when they do not directly impact resource access. *Specific and individualized* navigation may be key.

This issue's correspondence includes information about the opportunity for lactating people living with HIV to chest-feed/breast-feed infants.[10] Another letter reports on an outbreak of hand, foot, and mouth disease at a university.[11] Baltazar et al introduce readers to elastic scattering spectroscopy[12] with data from the experience of family physicians evaluating 155 patients' lesions. The first PURL for this issue includes the potential for less aggressive hydration for acute pancreatitis.[13] The second

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PURL reviews the relative efficacy of various medication classes for osteoporosis management.[14]

Policy Affects Patient Care

Many family physician offices will relate to the issues created by the marketing practices of Medicare Advantage programs as noted in a commentary by Bohler and Adashi.[15] The authors note the associated astonishingly high rate of complete or partial overturning of the initial plan decisions to deny patients' appeals, and their high average gross margin per enrollee. Many family practices feel this pain directly in the extra work generated and indirectly in the angst that patient needs are not met.

There are also health policy lessons in the report by Topmiller et al.[16] Primary care physician capacity and having a usual source of care do not always correlate and the ratio of primary care physician capacity to population varies by region. Thus, the type of health policy interventions needed to improve access to primary care may need to be targeted to geographic region.

Practice facilitation may not be familiar to all primary care clinicians. Cole et al[17] report on the perceived usefulness of different types of facilitated intervention strategies in 44 practices, which informs intervention priorities for others. The availability of practice facilitation likely needs encouragement by the provision of financial support.

Medical school policy also affects patient care through the type of, and expectations for, faculty. Alvarez et al[18] discuss 3 reasons why black and other minoritized faculty should be afforded the opportunity to achieve tenure status in their academic health centers.

Short, Interesting, and Helpful

We have several letters or short articles that address topics central to the practice of family medicine. For example, one provides an enthusiastic report about the use of person-centered, goal-oriented care to improve patients' Quality of Life (QOL),[19] and another set of authors write about their experience creating a unique direct primary care clinic[20] for patients from vulnerable communities. A third letter expresses concerns about the adequacy of data by race and ethnicity to assess early-career compensation trends for family physicians in a previously published article[21] with an explanatory reply by the authors of the original article.

To see this article online, please go to: http://jabfm.org/content/37/3/357.full.

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