EDITORS' NOTE

Clinically Relevant Family Medicine Research: Board Certification Updates

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A new Patient Psychological Safety Scale (PPSS) has potential to address an often-unrecognized problem. Should HbA1c be used to follow diabetes in patients with concurrent sickle cell disease? Are there significant differences resulting from HbA1c point-of-care versus send-off testing? Which treatment for which type of incontinence? Which factors are more predictive of emotional exhaustion for clinicians versus nonclinician staff? Does your office apply fluoride to young children's teeth? Is testosterone deficiency associated with death in older men? How does ChatGPT impact board certification exams? What is the most effective treatment for vasomotor symptoms associated with menopause? (J Am Board Fam Med 2024;37:805–808.)

Clinical Topics

In translational research to support patients and the clinicians who care for them, Hershberger et al[1] introduce the Patient Psychological Safety Scale (PPSS), including its development and characteristics. This scale could have significant clinical implications, particularly in certain circumstances.

Jehle et al explore the associations of testosterone deficiency with illness and death[2] in a cohort of more than 100,000 men, over 15 years from more than 50 organizations. The identified associations were both statistically and clinically significant.

Of the 5 types of incontinence, the first line treatment for 2 types is nonpharmacologic. Al-Dossari et al[3] review the options. The key is to find the right one, or right combination thereof, for each patient, with the needs often changing over time.

Fluoride application for children in family medicine offices is rare,[4] representing a missed opportunity to improve future dental outcomes, which in turn, influences long-term health outcomes. Does your office apply fluoride to young children's teeth? (If not, please consider, especially if you take care of patients who have a nonfluoridated water supply.)

For many practices, integrating behavioral health care is a goal, but not easily implemented. Nguyen et al[5] report on their successful 6-year intervention to integrate behavioral health into primary care at 10 New Jersey Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs). All sites maintained services after the end of the intervention. The intervention was based on the integrative behavioral health model developed by Cherokee Health Systems. The authors include enriching comments from participants.

In an excellent clinical review of vasomotor symptoms (hot flashes), Shrager et al[6] report the types of associations (including with menopause) and treatment options for this common problematic symptom that affects both men and women. The authors further tackle the breadth of the many potential treatments for the symptoms of menopause, with variations by socio-demographics and coexisting health conditions.

Wattanapisit and Wattanapisit[7] remind clinicians and patients that light intensity physical activity improves health – it does not take intense, lengthy physical activity to make a difference, as noted in the World Health Organization physical activity guidelines. Although many people think they must exercise harder than they think they can, the authors provide some suggestions – almost any amount is better than none (and, hopefully, work up from there).

In a letter to the editor Waters and Simon[8] discuss 2 major, yet distinct, decision points in opioid therapy: whether to start and whether to taper. Their comments were in response to a *JABFM* article by Licciardone JC et al.[9] on the effectiveness of

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long-term opioid therapy for chronic low back pain.

Caregiving responsibilities at home are frequently different for women and men and probably by profession and assigned professional roles. Willard-Grace et al[10] consider which of the following factors were more predictive of emotional exhaustion – gender, caregiving hours, or work support – for clinicians versus nonclinician staff. In another article,[11] a group of family physicians share how the minority tax extends beyond academic medicine spaces to clinical care. Both articles have implications for leaders and primary care offices.

Diabetes-Specific Care

A research letter[12] presents evidence that continuity improves quality of care (Johannes et al) – seeing the same clinician for only 1 additional visit within 3 years of diagnosis was associated with a decrease in the progression from prediabetes to diabetes. As noted by Carrithers et al,[13] the traditionally used HbA1c cannot be used to diagnose or follow diabetes in patients with sickle cell disease. This brief report explains this fact and provides recommendations on how to proceed.

Social Needs and Social Determinants of Health

Since its inception, family medicine has understood the influence and importance of family and community on patient health. Now, family physicians are increasingly discovering how to best assess and address social needs in clinical practice.

Sosso et al[14] investigated the association of multiple social risk domains on the attainment of a composite quality metric among 44,010 patients with type 2 diabetes. Verifying the potential positive outcomes of social work intervention, Solberg et al[15] provide evidence of what many already know – social work interventions, in coordination with primary care offices, have positive outcomes.

Alpert and colleagues[16] introduce readers to a 'taboo topic' and outline specific recommendations for how to talk to your patients about income. This tough conversation is inextricably linked to the social determinants of health of patients. Even within a *fully insured* population with high screening rates, respondents with financial strain, social isolation, and food insecurity had lower odds of being up to date with colorectal cancer screening.[17] Future efforts should assess how addressing patients' social needs could lead to increased CRC screening rates.

Chan and colleagues demonstrate that the benefits of intensive primary care go beyond reducing costs and utilization.[18] Have you heard of an ambulatory ICU, and particularly in association with an Urban Homeless clinic? Certainly, finding useful answers for these patients is worthwhile.

In the Special Communication category,[19] the "Latino Paradox" was the topic for a summit that involved scholars from many universities and across 6 themes, with emphasis on the United States context. As noted by the authors, lower overall mortality among Latinos belies the extent and type of health issues that should be considered to improve this group's health. Particular consideration should include the broad range of different groups within the "Latino" categorization. The summit identified several areas for further research. Themes noted include health system wide challenges for patients whose preferred language is not English and the importance of racial and ethnic concordance between patients and the physician workforce, which was also discussed in Santiago-Delgadoet al.[20]

Advancing Research in Family Medicine

Peek and collaborators[21] detail the history and highlight the improvement for both research itself and the ability of research by groups of practicing clinicians to impact the practice of family medicine. The article highlights how Ambulatory Sentinel Practice Network (ASPN) and National Research Network (NRN) emerged and then changed primary care, family medicine, and the direction of research nationally. This article is dedicated to the late Dr. John Hickner who was a strong, persistent leader in the development and evolution of practice-based research networks.

Policy & Board Certification

Gender affirming care is increasing, as noted by Barr et al.,[22] and family physicians experienced with this type of care provide additional commentary.[23]

Board-certified family physicians have 2 primary choices to remain board certified – an examination at a testing site every 10 years, or quarterly online testing with specific time limit per question.[24] The

authors explore the differences between the 2 types of tests and outcomes for the certificants. Recently, the American Board of Family Medicine (ABFM) announced the cycle for recertification will become 5 rather than 10 years.

Many *JABFM* readers are family physicians who certify and recertify through the ABFM. Concurrently, many people in various circumstances are scared of the implications of ChatGPT. Well, perhaps there is another reason family physicians fear: Wang et al[25] used Chat GPT-4 version with the recent recertification examination, and Chat GPT-4 did, well, actually *very well*, and significantly better than Chat GPT-3 did recently.

PURLs

A new PURL[26] describes the use of DOACs, now preferred over other anticoagulation for certain indications, such as atrial fibrillation with concurrent reduced renal function. The reasoning for this recommendation is included in this brief overview of a meta-analysis.

To see this article online, please go to: http://jabfm.org/content/37/5/805.full.

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