EDITORIAL

In This Issue: Tools to Help Focus on What is Valuable

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This issue brings to light tools and techniques to help clinicians, patients, and policy makers focus on what is important amidst a cacophony of competing demands.

The prioritizing function in primary care[1-3] is one of the underappreciated reasons why health care systems that support primary care have healthier populations, greater health equity, and more sustainable costs.[4] The way of the generalist begins with a broadly inclusive gaze and an investment in relationships.[5-8] The generalist scans patients' acute complaints, life events, multiple chronic illnesses, and health promotion and disease prevention opportunities within family and community context, in order to put attention on the particulars[9] that might do the most good in the moment.[10] The generalist then raises the gaze to act on each particular from the perspective of its larger context.[11-13] Usually this involves iteratively re-prioritizing and then providing care for multiple problems[14,15]; sometimes it involves coordinating care within an otherwise fragmented system.[16,17] The articles in this issue can help with the prioritizing function that is under-recognized, undervalued, but vital.

Shaughnessy and colleagues develop and evaluate the Guideline Trustworthiness, Relevance and Utility Scoring Tool. "G-TRUST" appears to be useful for helping clinicians identify which among an overabundance of clinical guidelines might be helpful in informing care for their patients.[18] In an accompanying editorial, LeFevre notes that although guidelines were developed to make it easier to bring science to clinical care, the glut of guidelines developed by consensus panels is actually moving us backwards toward authority-based medicine.[19]

In an article featured in *Annals* Journal Club, Arndt and colleagues use electronic health record event log data and time-motion observations to identify areas for improvement in supporting family physicians' allocation of time for patients. They find that more than one-half of a physician's 11.4-hour work day is spent in the electronic health record—both during and after clinic hours. Nearly one-half of this time is spent in clerical and administrative tasks.[20] Join the moderated *Annals* Journal Club Twitter chat (#AJC), on Wednesday October 4 at 12:00 pm EST / 16:00 GMT.

A potential solution to this dilemma, or at least a patch on the problem, is evaluated in a clinical trial by Lin et al. They randomize family physicians to alternating weeks with and without an electronic health record scribe. Having a scribe improves physician satisfaction with face time with patients, time spent with charting, and charting accuracy, while having no effect on patient satisfaction, and increasing the proportion of charts that were closed within 48 hours.[21]

Growing interest in population health[22-35] is limited by practical methods for applying its principles in practice.[26,29-31,33,36,37] A special report by Kaufman and colleagues reports on how the concept of "health extension" is manifested in practical ways by Cooperative Extension Services in several US states. This report shows how initial skepticism and protectionism can be overcome with shared priority setting, decision making, and funding from new sources, and through developing practical collaborative projects that build personal relationships and trust.[38]

To focus their attention on high-risk patients, practices use 4 methods, according to Reddy and colleagues. In their study of practices participating in the Comprehensive Primary Care (CPC) initiative developed by the US Centers for Medicare and Medicaid Services with the intention of strengthening primary care, practices stratify their patient populations by using: practice-developed algorithms, AAFP clinical algorithms, payer claims or electronic health record methods, and clinical intuition.[39] These different approaches may have complementary strengths and weaknesses.

It is important to develop both systems and personal habits that minimize risks to patient safety. In a study of incident reports, Cooper et al find a high rate of blame and retribution.[40] A focus on blame is likely to get in the way of identifying opportunities for learning and for systems improvement.

Two studies in this issue help us to focus on the needs of adults with developmental or intellectual disabilities. Carey et al, in a large study of patients from 343 general practices in the United Kingdom, find that adults with intellectual disabilities are at high risk of

preventable emergency hospital admissions.[41] A research brief by Havercamp and colleagues amplifies these findings by discovering that people with developmental disabilities have disparities in health status, quality of care, access, utilization, and unmet health care needs.[42]

Focusing on patients at high risk and at teachable moments are common strategies in primary care. A study from UK general practices finds that all risk factors are not created equal. General practitioners are less likely to support smoking cessation in patients with lung, bladder, and upper aerodigestive tract cancer than coronary heart disease, and patients with cancer are less likely to stop smoking.[43]

In a study of 870,319 community health center patients, Holderness et al find a very interesting pattern of large and unequal reductions in the rate of uninsurance in 10 states that expanded Medicaid and 6 states that did not.[44]

This issue continues the new *Annals* feature on Innovations in Primary Care.[45,46] The innovations in this issue include a novel office-based opioid treatment program developed by an interdisciplinary team at a regional health and education center[47] and a Massive Open Online Course (MOOC), available free to all who have Internet access, that educates participants about falls and fall prevention.[48]

We also are delighted to introduce the first virtual issue of Annals of Family Medicine. A virtual issue curates previously published articles, and draws new meaning from their collective content by bringing them together with a new editorial. This inaugural virtual issue addresses the intersection of clinical primary care and public health.[49] The groundbreaking introductory editorial by Orkin et al uses the term Clinical Population Medicine to describe the "application of population health approaches to care for individual patients and design health care systems."[50]

We welcome you to join the online discussion for each of the articles at http://www.AnnFamMed.org.

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