
EDITORIAL

In This Issue: Tech, Touch, & Templates for Understanding and Improving Care

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This issue is about tech, touch, and templates for understanding and improving care. The technology is a mix of high- and low-tech. The touch is a blend of careful listening and personal reflection. The templates involve helpful models for making sense of complex care.

In a randomized controlled trial by Regan et al, text messaging offers a technological solution to the challenge of focusing influenza immunization on high risk individuals. For every 29 text messages sent (costing \$3.48 USD), 1 additional high-risk patient is immunized, with the greatest effect in texting parents of children aged under 5 years.¹

The simple technology of a single physical exam maneuver—assessing whether a murmur disappears upon standing—proves to be an effective and practical method for discovering if a child's heart murmur is clinically important. Lefort et al prospectively evaluate 194 consecutive children aged 2 to 18 years referred to pediatric cardiologists for evaluation of a heart murmur. They find that the disappearance of a murmur while standing excludes a pathological murmur with positive predictive value of 98%, specificity of 93%, and sensitivity of 60%.² This article is featured in the *Annals Journal Club*.

An established technology (compression ultrasonography), touched by a new user (general practitioners), proves to be a reliable tool for diagnosing deep venous thrombosis in a multicenter prospective cohort study by Mumoli et al.³

The high tech of big data and low tech of qualitative assessment combine in a study by Milstein et al to identify and explain care delivery attributes associated with high value, as defined by Medicare's merit-based incentive payment system.⁴

The high touch of shared decision making between patient and clinician is depicted as an ideal, but may not be desired by all patients in all situations.⁵ In a nationally representative sample of more than 2,000 older US adults, Chi and colleagues find that while the majority of older adults prefer to participate actively in making health care decisions, adults with 4 or more

chronic conditions, and those with certain clusters of conditions, are relatively less likely to prefer active decision making.⁶ These findings can help us tailor approaches to shared decision making based on what patients want. The study implies that shared decision making sometimes involves more subtlety than is commonly acknowledged. In some cases, sharing a decision might involve ascertaining patients' values and wishes through subtle means, over time or at key moments, and using that shared knowledge to offer individualized care that might not look like shared decision making to the casual observer or the researcher using measures of overt manifestations.

Another perspective on shared decision making comes from a study by Levine et al, that identifies a 12-year national trend toward increased shared decision making, and different patterns based on patient characteristics and the match of patient and clinician characteristics.⁷

A large and rapidly growing body of research shows the growing influence of multimorbidity on people's lives and health care use. A new framework based on published care models provides a template for beginning to make sense of care, intervention, and research possibilities for people living with multimorbidity. The framework clarifies underlying theory, target populations, and intervention elements.⁸

The repeated touches enabled by continuity of care appear to be an antidote to emergency hospital admissions, in a study of records from 10,000 patients.⁹ The argument for causation is strengthened by the observed dose-response pattern. Balint's notion of doctor as drug¹⁰ finds support in this study.

The high-touch reflections in an autoethnographic examination by Frankhouser help us to deeply identify what it means to live with post-partum depression.¹¹

Medications with anticholinergic effects can have many unintended consequences. In a longitudinal study of more than 100,000 patients, Hsiao et al find that 3 measures of anticholinergic burden show a dose-response relationship with several important health outcomes, including emergency department visits,

all-cause hospitalization, hospitalization for falls, and incident dementia, particularly among the elderly.¹²

In an electronic medical record study of 8,142 patients, Clarson et al assess factors associated with potentially beneficial earlier initiation of allopurinol treatment.¹³

Reflections of "a resident passing through" provide insights into the formative effects of conflicted yet deep physician-patient relationships.¹⁴

An essay by Loxterkamp dives below the surface of usual explanations for clinician burnout, and asks us to consider the need for deep connection and sense of purpose in developing workplace cultures and communities.¹⁵

The *Annals* feature on Innovations in Primary Care¹⁶ shows the potentially transformative effect of expanding clinic huddles,¹⁷ and of an Accountable Care Organization's advocacy and leadership to increase the supply and demand for healthier foods and reduce the promotion and availability of less healthful options.¹⁸

Finally, to all authors of manuscripts involving quantitative data, I commend the engaging and enlightening editorial by *Annals* Statistical Editor Miguel Marino.¹⁹

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

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CORRECTION

Ann Fam Med 2017;15:503. <https://doi.org/10.1370/afm.2168>.

In the September/October issue of *Annals of Family Medicine*, Sunil M. Shah was incorrectly listed on the print cover of the journal as an author of "Preventable emergency hospital admissions among adults with intellectual disability in England," (*Ann Fam Med.* 2017;15(5):462-470). The print issue therefore deviates from the online version. We regret the error.