EDITORIAL

In This Issue: From Communities of Solution to Joy

Kurt C. Stange, MD, PhD, Editor

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This issue features a bold proposal for community-focused approaches to improving health. While the approaches are new, they build on a blueprint from more than 40 years ago. In addition, a cluster of articles present new knowledge for the care of diverse groups of vulnerable people. Another clinical research article summarizes scientific evidence for a limited nonantibiotic treatment for sinusitis. A novel proposal and an editorial consider paying patients for "performance" reaching measurable health goals, while a study of a large scheme for paying practices for performance is shown to have no effect on reducing ethnic disparities in management of diabetes. A study of the effect of electronic health records on diabetes care improvement, a useful methodological reference for practice-based research, and an essay that reveals a path toward the joy of family medicine, round out the issue.

COMMUNITIES OF SOLUTION

In a report proposing communities of solution, a group of rising family medicine leaders, calling themselves the Folsom Group, revitalize and modernize the grand challenges from the landmark 1967 Folsom Report.[1,2] This proposal for vitalizing community-centered approaches to improving health calls on the best traditions of local action, public health, and primary health care. A recent Institute of Medicine report[3] recommends both federal and local efforts that will support the Community of Solution vision. And around the country and in whole systems around the world varied partners and multistakeholder groups are working together to address problems and create opportunities to improve the health of their communities. The *Annals* editors encourage readers to share your experiences of communities of solution and develop ideas for realizing even a portion of this expansive vision: log on to the TRACK discussion of articles at http://www.AnnFamMed.org. The *Annals* Journal Club[4] provides questions to guide group discussion.

UNDERSTANDING AND IMPROVING CARE FOR VULNERABLE PEOPLE

A randomized clinical trial by Margolis and colleagues[5] finds that home blood pressure monitoring and weekly health coaching are associated with reduced blood pressure in low-income minority patients with poorly controlled hypertension, but it finds no effect of home titration of blood pressure medications.

For older adults with low levels of physical activity, Kolt and colleagues[6] assess the effect of a "green prescription"—a recommendation for physical activity with pedometer monitoring. In a clinical trial of 330 adults older than 65 years, they find that a green prescription increases leisure walking without an effect on overall activity levels.

In a qualitative study of women in Lebanon, Usta et al find that even in a conservative society, most women want their clinicians to assess the possibility of domestic violence, and they want their health care system to address what is uncovered.[7]

Pay-for-performance schemes have been touted as a route to reducing health care inequalities. In a study in the UK's Quality and Outcomes Framework (QOF), Alshamsan et al find that introduction of QOF had no effect on health care inequalities in 29 general practices.[8]

CONTROVERSIAL TOPICS

As evidence and clinical policy recommendations move away from antibiotic use for acute sinusitis,[9] a helpful meta-analysis by Hayward and colleagues finds a small therapeutic benefit from intranasal corticosteroids.[10] The effect is not apparent until 2 to 3 weeks, however, and most studies also included antibiotics, making it difficult to tease out the independent effect of steroids. An editorialist[11] is skeptical about anything but limited use of intranasal steroids for selected patients with sinusitis.

An essay by Wu proposes paying patients for per-

formance by rewarding them for achieving evidence-based health goals.[12] An editorial by Christiansen[13] supports the concept of reinforcing positive behavior but argues that the literature on incentives does not yet justify such a proposal.

METHODS, THE ELECTRONIC HEALTH RECORD, AND JOY

In an interesting spin on the term "meaningful use" of electronic health records, Crosson et al find no association of electronic medical record use and measures of the quality of diabetes care over a 3-year period.[14]

Thompson and colleagues provide information on clustering of data from more than 5,000 patients in 61 practices in 8 practice-based research networks across the United States.[15] The details of these intraclass correlation coefficients across multiple patient characteristics, practices, and networks will be of use to practice-based researchers in planning studies to assure adequate statistical power.

Finally, an essay by Ventres shares the personal joy of being a family physician and suggests 6 themes that continue to rejuvenate his practice.[16]

We welcome your reflections on all articles at http://www.AnnFamMed.org.

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