EDITORIAL

In This Issue: Team-Based Care and Information to Improve Practice

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Articles in this issue of *Annals* enlighten development of effective primary health care teams and inform efforts to improve practice.

Relationships among members of the primary care team have been shown to be vital to the development of effective practices.[1] Three studies in this issue examine work relationships and practice change in primary care practice.

Three different approaches for practice change are evaluated in a cluster randomized trial by Dickinson et al.[2] The comparison of continuous quality improvement, reflective adaptive process, and self-direction for implementing the Chronic Care Model shows trade-offs in improving diabetes quality measures and fostering practice and work culture change.

A qualitative study of small to midsized practices involved in a patient-centered medical home initiative examines strategies for engaging the entire practice in change efforts. The 13 identified strategies cluster into 3 themes that relate to effective internal communication, resource use, and creation of a team environment.[3]

A broad look at efforts to improve diabetes quality measures is taken by Peterson and colleagues[4] in their evaluation of family physicians across the United States completing a diabetes Performance in Practice Module to meet recertification requirements of the American Board of Family Medicine. Among physicians completing nearly 8,000 modules, nearly one-half of all quality measures improved.

A cluster randomized trial of melanoma screening and education interventions finds improvements in patient knowledge, screening, and prevention behaviors.[5]

A mixed methods study discovers practical opportunities for health behavior change for diet and physical activity. Using the Capability Framework and a community-based participatory approach, Ferrer and colleagues identify how the resources available in an economically disadvantaged community interact with personal circumstances to create capability or vulnerability.[6]

The utility of a single question about health to determine which patients are at risk for poor long-term depression outcomes is discovered by Ambresin and colleagues in a prospective study in 30 primary care practices.[7]

In an article that adds to Ebell's recent study of patient expectations for antibiotic for a cough,[8] Mustafa and colleagues[9] use qualitative methods to find that practicing family physicians use indirect methods to explore expectations for treatment and their physical examination to build an argument for reassuring the patient or parent when antibiotics are not needed. These findings of the practices of experienced family physicians contrast with more academic communications literature and suggest that much might be learned from carefully examining the practices of those in real-world practice.

Systems thinking has tacitly and sometimes overtly influenced the thinking and action of primary care for decades. In a historical, integrative review, Sturmberg and colleagues describe the interrelated development of general practice/family medicine and understanding of complex adaptive systems theory.[10]

Annals Journal Club for this issue features the article by Mustafa and colleagues that explores ways to reduce inappropriate antibiotic prescribing by managing expectations.[11]

Finally, this issue publishes an archival manuscript from the (at the time) youngest generation of participants in the Keystone III conference that led to the Future of Family Medicine Project.[12,13] Three editorials[14-16] invite you to a conversation about what can be learned across generational differences.

We welcome your reflections at www.AnnFamMed.org.

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EDITORIAL

The Changing World of Family Medicine: The New View From Cheyenne Mountain

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Electronic health records. Smart phones. Near-universal broad-band Internet access. Asynchronous communication. Electronic visits. Telemedicine. Patient-centered primary care homes (medical homes). Team-based care. A wide range of practice models. Hospitalists. Value-based purchasing. Accountable care. In the 13 years since the Keystone III conference that set the stage for the Future of Family Medicine (1.0) initiative, which attempted to renew and transform the discipline of family medicine, these innovations have all become commonplace, resulting in one of the most substantial transformations of primary care practice in the past century. The 10 members of the Generation III (youngest generation) group at the conference have been closely involved with many of these changes through practice, policy, research, and medical education; in many ways these changes represent a microcosm of the diversity among family physicians today.

As our original article makes clear, the definition of the "ideal" family physician was a recurrent theme during the Keystone conference. Those of us in Generation III, some late baby boomers and some early Gen Xers (those born 1964-1985), undoubtedly had expectations of work-life balance, the scope of our practices, and how we might structure our practices and careers that were different from those held by Generations I and II. Over the intervening years, it has become evident that one might best describe the ideal family physician as a pluripotent stem cell; our generalist inclination, diverse training, and range of meta-skills (listening, systems thinking, team-building, advocacy, etc) allow family physicians to pursue a wide range of careers both in and out of medicine, and even change

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