

In This Issue: Diabetes Quality of Care

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LINKING PRACTICE-BASED RESEARCH NETWORKS AND COMMUNITY-BASED PARTICIPATORY RESEARCH

Two important and, until recently, undervalued research traditions are brought together in a research study, a case study, and an editorial in this issue. The study by Westfall and colleagues¹ surveys practice-based research networks (PBRNs) and finds that more than one half have a method to engage community members and/or patients in their research. In a related case study available online in the *Annals*, the Community Advisory Council for the High Plains Research Network describes their experience of participating in practice-based network research.² These articles show the potential for PBRNs to bridge the gap between clinical research and community needs. The editorial by Macauley and Nutting highlights the potential of bringing together PBRN research and community-based participatory research to solve some of the most intractable problems facing health and health care.³ This approach is the kind called for by the NIH Roadmap.⁴ Westfall and colleagues and Macauley and Nutting show us the way. If primary care researchers, academic health centers, communities, and primary care practices can come together around a vision for community- and practice-based participatory research, we can reduce the problem of translating research into practice by translating practice and community life into research.

DIABETES DIAGNOSIS AND MANAGEMENT

This issue features 5 studies that address diabetes quality of care from innovative viewpoints. These research frameworks are grounded in the perspectives of health care systems, front-line practice, and consideration of how diabetes care is nested within care of other important conditions.

In a large study of a cohort of adult patients in a multispecialty medical group, O'Connor and colleagues examine the symptoms, clinical incidents, and types of

health care visits that precede the diagnosis of diabetes mellitus.⁵ They identify markers for the new diagnosis and go further to track the course of important clinical parameters after the diagnosis. The findings are useful in considering how systems and practices might enhance their early recognition and treatment of diabetes. The reduction in risk factors apparent after the diagnosis in this large multispecialty group hints that earlier detection and treatment might be worthwhile.

Spann and colleagues⁶ provide a snapshot of diabetes care across the United States in a national PBRN. The study finds both patient and practice factors that are associated with better process markers of quality care; the authors conclude that substantial practice redesign may be necessary to achieve markedly improved chronic illness care.

Three innovatively conceptualized studies in this issue put diabetes care into the context of other competing demands. Fenton and colleagues⁷ examine how diabetes process-of-care-quality measures are related both to frequency of visits and to whether visits are for lower-priority conditions based on the Oregon State Prioritized Health Service List. Parchman et al⁸ examine how the delivery of recommended diabetes care services is related to the type and duration of the outpatient visit and time to the next encounter. They conclude that competing demands require prioritizing and sometimes deferring services to subsequent visits. Lin and colleagues⁹ use a randomized clinical trial to test whether an intervention for an important competing demand, depression, can improve self-management of diabetes.

One reason that diabetes currently is the sweet-heart of the quality improvement movement is that it is relatively easy to measure evidence-informed process measures of quality of care that are much harder to come by for other diseases.¹⁰ The quality-of-care studies in this issue either explicitly or implicitly call for the development of systems that not only support evidence-based care of diabetes, but also foster the integration of care for chronic illness, mental health,

and prevention. In my opinion, current informatics support systems and pay-for-performance conceptualizations are not up to the task. A large and vital task is to develop systems that integrate care rather than just improve the quality of parts of care. Without a focus on this integration, our efforts to improve quality may not result in the desired effects on the level of the whole person and the system. A focus on the parts, without attention to integrating the whole, may not improve health and may have unintended consequences.¹¹

QUALITY, COMMUNICATION, ANGER, AND DEPRESSION

In a study using an intensive stimulated recall method for assessing videotaped outpatient visits, Saba and colleagues¹² examine the experience of partnership by patients and physicians. Both relationship factors and communication behaviors influence the experience of collaboration. Using recorded visits to stimulate recall can be a powerful method for understanding the experience of health care from the perspectives of both the patient and the physician and for generating common understanding.

An interesting case control–case crossover study examines the relationship between states of anger and risk of injury among emergency department patients.¹³ Anger is associated with intentional injury inflicted by another person, but not with fall and traffic injuries.

In a study of depressed patients, Solberg¹⁴ et al examine the effect of a natural experiment that improved access to primary care in a large, multispecialty medical group. Improved primary care access is associated with improved follow-up after starting a new antidepressant, apparently due to improved continuity of care. The findings show a potential benefit of system redesign to improve access and continuity of care.

Finally, 2 essays provide a human face to this issue. Borkan¹⁵ shares a compelling medical and social drama and uses the event to depict the ways in which stories foster sense-making and deeper meaning. In another essay, a resident physician tells the story of an elderly patient being kept alive beyond his wishes.¹⁶ The shared experience helps shape the resident's perception of the physician's role in end-of-life care.

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