Capsule Commentary on Kaplan et al., Reducing Racial/Ethnic Disparities in Diabetes: The Coached Care (R2D2C2) Project

Jeffrey L. Jackson, MD, MPH

Division of General Internal Medicine, Zablocki VA Medical Center, Milwaukee, WI, USA.

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One of the most troubling aspects of US medicine is the level of disparities in health and healthcare outcomes.^{1–3} While previous work has generally focused on one or two potential contributors, the paper by Kaplan et al. examines a myriad of patient, provider and system characteristics to explore the source of disparities in diabetes control among Mexican-Americans.⁴ The differences in glycosylated hemoglobin seen between Vietnamese-Americans, non-Hispanic whites and Mexican-Americans were explained by differences in gender, age, duration of diabetes, education and income level and insurance status. While statistically significant, communication markers such as communication quality, trust, language barriers and participatory decision-making style explained no additional variance in outcomes.

Targeting disparities reduction will require understanding the source of these differences. Determining how much improvement is amenable to modification by healthcare systems is also useful; it may prove less than we hope. In this study, most of the factors contributing to the difference, such as age, gender, diabetes duration, education attainment and income level are outside the influence of healthcare systems. It is also discouraging that communication had no

impact. While improved patient–provider communication is a healthcare goal, lapses in communication quality having been frequently observed, demonstrating that other than trust or satisfaction, better communication improves patient health outcomes, yet has proven elusive.

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Corresponding Author: Jeffrey L. Jackson, MD, MPH; Division of General Internal Medicine, Zablocki VA Medical Center, Milwaukee, WI 53295, USA (e-mail: jjackson@mcw.edu).

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