

# Escaping the Tyranny of the Urgent by Delivering Planned Care

These four components can help you provide care that is more proactive, organized and satisfying.



**M**uch of our work in primary care could be characterized as reactive and chaotic, rather than proactive and organized. The scenario is so common, it barely merits description: A patient with uncontrolled hypertension scheduled for a 15-minute follow-up visit complains of an upper respiratory infection, so you treat the URI and then quickly adjust the patient's hypertension meds and exhort the patient one more time to please follow through and get that colonoscopy. Blearily dictating your note later that night after the kids are in bed, you realize that you haven't followed up on the patient's iron deficiency anemia in ages, and you wonder

if the lack of refills on thyroxine is a charting error or if the patient has just stopped taking the medication.

This tyranny of the urgent, or tyranny of the presenting problem, often prevents us from providing high-quality care and contributes to the gap in performance documented in recent literature.<sup>1</sup> As described in the Institute of Medicine (IOM) report *Crossing the Quality Chasm*, the gap exists in spite of our professionalism, hard work and dedication – and will not be closed with greater amounts of professionalism, hard work or dedication.<sup>2</sup>

What will close the gap? Long before the publication of the IOM report, a group of researchers and clinicians

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got together to figure out how to close the gap between typical practice and the growing evidence base of what we ought to be doing in our practices. The early group eventually morphed into the Improving Chronic Illness Care collaborative (<http://www.improvingchroniccare.org>) sponsored by the Robert Wood Johnson Foundation, and what they developed eventually became known as the Chronic Care Model. Over time, this Chronic Care Model has expanded to include preventive care and is now commonly referred to as “planned care.”

This model of care involves a heavily researched set of components that, when successfully implemented in practice, leads to improved interactions between informed, activated patients and a prepared, proactive care team. Four of the components – clinical information systems, decision support, self-management support and delivery system design – can be addressed fully within the four walls of a practice. The last two components – organization of the health system and community resources and policy – are left for another article.

This article describes how I’ve gone about delivering planned care in my practice.

## Clinical information systems

Clinical information systems are the first requirement in providing planned care, as

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they facilitate two important practices:

**Opportunistic care.** When patients present with acute problems, practices need to go beyond the chief complaint and delve into preventive care and chronic conditions. The ability to address gaps in preventive and chronic disease care – aka opportunistic care – is a lot easier with good clinical information systems. Rather than having to pull a paper chart and find a disease-specific flow sheet, physicians working in an electronic environment have instant access to information about more than just the diseased organ system.

My practice, which consists of just myself and one nurse, operates with the help of an electronic health record system. When a patient calls our practice for any reason, we instantly pull up the chart and review key screens for gaps in care. A typical conversation might go like this: “Yes, Mr. Jones, your referral is all set. By the way, I see we have no note of you ever getting a pneumonia shot. Would you like to drop in for the vaccine? We can update your blood pressure and weight at the same time if you’d like. By the way, how is that walking program of yours going?”

**Outreach.** Our ability to identify and address gaps in care as a part of any interaction helps our patients achieve better outcomes, but this approach misses an important population: those patients who do not call or come in to our practice. When we accept patients into our practice, we accept responsibility for their health care. Until they disenroll, we are responsible for doing all we can to help them achieve the best possible outcomes.

In my old practice, I would have written off as “noncompliant” all of those patients who never called or came in for their hypertension rechecks. This attitude results in only 29 percent of patients with hypertension achieving their blood pressure goal.<sup>3</sup> In contrast, in practices using clinical registries coupled with

■ The planned care model leads to improved interactions between informed, activated patients and a prepared, proactive care team.

■ With adequate clinical information systems, physicians can more easily go beyond the chief complaint and address gaps in preventive and chronic disease care.

■ Tools such as a simple disease registry can help physicians reach out to patients and provide needed care.

# remember every drug, every interaction for every patient every time.

outreach efforts, between 80 percent and 90 percent of hypertension patients are at goal. In our practice, between 70 percent to 80 percent of patients with hypertension are at goal.

Outreach starts with the ability to track a population regardless of whether they come to your office. A registry – a list of patients, their conditions and key measures – can be as simple as a card file or as fancy as a computerized system. (For more on registries, search <http://www.improvingchroniccare.org>, visit <http://www.cdems.com> or read “Using a Simple Patient Registry to Improve Your Chronic Disease Care,” *FPM*, April 2006.) In our practice, we use a computerized registry. Once a month, the nurse care manager in my practice (Judy Zettek, RN) generates a list of patients who have exceeded certain limits: Either it has been too long since their last contact with our practice or their absolute values are not yet at the target. Judy then contacts these patients to see what she or I can do to help them achieve their goals.

Patients with simple conditions such as a lipid disorder might only need reminder letters. Patients with more complex chronic conditions – especially those who lack confidence in their ability to manage their condition – might benefit from more aggressive care management, including regular follow-up contact either by e-mail, by phone, in a face-to-face visit or in a group visit.

## Decision support

It is inhuman to expect that we will remember every drug, every interaction and every guideline algorithm for every patient every time. Thank goodness tools are popping up to help us avoid risky, seat-of-the-pants decision making. The following decision-support tools have been particularly helpful to me in my practice.

**1. Guidelines.** While clinical guidelines

are often too complex and limited by a single-disease view of the world, they can be adapted into useful clinical support tools. For key clinical conditions, find the guideline that makes the most sense and appears to have the best pedigree in the literature. Then, embed the essential parts of the guideline into your work flow, for example, by creating a visit note template built from the guideline. (The Point-of-Care Guides published in *FPM* provide examples of disease-specific visit note templates based on evidence-based guidelines; see <http://www.aafp.org/x28028.xml>.)

**2. Prescribing assistance.** Get a personal digital assistant if you don't already have one, and download a program that allows you to look up medications at the point of care. Two free programs are MobilePDR (<http://www.pdr.net/>) and Epocrates Rx (<http://www.epocrates.com>). These tools can help you quickly access information about a drug's indication, dosage and contraindications and check for harmful interactions.

**3. Online clinical help.** A number of companies have created online tools that can assist you in answering medical questions quickly. They include DynaMed (<http://www.dynamicmedical.com>), FIRSTConsult (<http://www.firstconsult.com>) and InfoPoems (<http://www.infopoems.com>). Using online clinical resources still takes time, but if you keep a browser open on the exam room computer and, with practice, learn how to search quickly, you'll be able to find the information you need efficiently – and impress your patients. I have heard only positive comments from patients when I search online.

**4. Patient handouts.** Having easy access to patient education materials on a wide range of topics can be a tremendous help in equipping patients to improve their health. I use free materials from FamilyDoctor.org (<http://www.familydoctor.org>), the AAFP's patient

Decision support tools help physicians to remember critical details related to their patients' care.

Clinical guidelines can be helpful if physicians embed them into their workflow.

A variety of computer programs are available to equip physicians with the latest information about drugs and diseases.

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education site) and MedlinePlus (<http://www.medlineplus.gov>), and print them on demand right in the exam room.

## Self-management support

Patients are going to do what they want once they leave our offices, so the best we can do is give them the right information, assist them in making good choices and support them as they try their best to achieve their personal goals.

We aim to meet our patients “where they are” and help them move forward in a way that works for them. We’ve often found that patients will make significant movement if we open up to their approach to improvement. For example, if a smoker who has asthma is not ready to quit smoking but is finally willing to start a maintenance inhaler and use a peak flow meter, we support and celebrate her small steps. That doesn’t mean we give up on smoking cessation; we are confident that she will stop smoking in time, but she may first need to gain confidence in her ability to manage her disease.

I find that offering this type of self-management support is a much more satisfying mode of practice. No longer do I find myself frustrated by those darned noncompliant patients. Instead, I ask: “Are you ready to do something different about your diabetes? Are there any questions I can answer?” I’m surprised by how often people will open up and say that maybe they are ready to try again. I don’t always agree with the choices my patients make, but I no longer sit in judgment of those choices.

## Delivery system design

Implied in each of the above components is a redesign of the way we work. Providing planned care is not possible if we simply tack on the above strategies to our current practices. Instead, we must redesign our processes to make it possible for physicians and their staff to provide

proactive, efficient, patient-centered care.

I’ve redesigned my practice in a number of ways. For example, our practice uses the “care team” approach,<sup>4</sup> which requires regular communication among physicians and staff members, ongoing feedback, clear goals and roles, quick action and simple processes. We have eliminated waits and delays for our patients through implementation of open-access scheduling.<sup>5</sup> We use our information systems to help us measure and continually improve our processes to meet the needs of our patients. And with the help of our registry, we reach out to patients, offer group visits and provide care management.

## Bottom line

Planned care is a powerful vehicle to help us close the gaps and improve patient care in the United States. In addition, it makes the practice of medicine feel more organized and more satisfying. Rather than feeling caught in the tyranny of the urgent, we can feel confident that we have provided high-quality care that meets the needs of our patients and ultimately makes our work more rewarding. **FPM**

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2. Committee on Quality of Health Care in America, Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academies Press; 2001.
3. Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med*. 1997;157:2413-2446.
4. Moore LG. Creating a high-performing clinical team. *Fam Pract Manag*. March 2006;38-40.
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■ While physicians cannot change their patients’ behavior, they can take steps to engage them and equip them for self-management.

■ Meeting patients where they are and helping them take a step forward can be a much more satisfying mode of practice.

■ Planned care isn’t accomplished by tacking on new strategies to old practices; instead, it requires a redesign of the way physicians work.