EDITORS' NOTE

# Change, Lack of Change, and Creating Optimal Change Out of Chaos

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**Once again, we consider how to effect practice change at the local and national levels. This issue includes several articles that relate to quality improvement. Some physician actions seem resistant to change, as do the underlying social determinants and processes that lead to what are thought to be avoidable hospitalizations, but we also find that concerted effort, along with standardized orders sets and other avenues, can make a difference. Sometimes, however, our attempts at change can lead to more distraction then efficacy. Here we include articles that place the quality issues in context, report interventions, and advance the types of specific knowledge that allow interventional trials. We also have several articles about cancer screening and follow-up, a subset of quality improvement.(J Am Board Fam Med 2011;24:625–627.)**

## Quality Improvement

Baird[1] provides us with a fascinating historic and nuanced reflection of how and whether medical homes represent something new or otherwise different from former attempts at reform in family medicine, specifically managed care. In light of previous inflated expectations of the ways in which reforms can change medical care, he says, "no villains allowed."

Information chaos is clearly one of the reasons that we struggle to improve quality to a desired level. Beasley and colleagues[2] provide a structure to consider the information chaos, the negative outcomes of the chaos, and some direction for future research. This construct also relates to our tongue-in-cheek, yet provocative, selection from Baxley et al.[3] who suggests that we sometimes act as if we have attention deficit disorder as we attempt to implement multiple concurrent Plan-Do-Study-Act practice improvement projects. It is a variant of a "quality improvement disorder." Therefore, some remedies are in order. However, the answer is not to just take a pill daily and hope it will go away. Hopefully, we can improve the quality of our quality improvement activities.

In one major attempt to improve health care nationally, the Affordable Care Act mandates that the Centers for Medicaid and Medicare Services (CMS) implement a 10% payment increase for primary care. CMS criteria defining primary care are unfortunately currently inadequate to the task because they exclude many family physicians, particularly those in more rural settings or those who provide a broader range of services, as documented by research from the Robert Graham Center.[4]

On to specific examples from the articles in this issue. We know that preventable hospitalizations vary by location, but just how easy are these to avert? Sumner et al[5] determined that the differences in preventable hospitalizations between the counties in Kentucky persisted over time. This suggests that underlying problems or processes are not readily changed, and that needed health care improvements will be relatively resistant to transformation.

Another specific quality improvement item that seems resistant to change is the ordering of urine cultures for women with urinary tract infection symptoms. Obtaining urine cultures has not been found to improve outcomes. However, physicians keep ordering them, which leads to the question posed and answered by Johnson et al[6]: If we are going to order a urine culture, does it at least decrease the number of follow-up visits for the urinary tract infections? Within this group of almost 800 patients, sadly, the answer seems to be no. We need additional research to understand what

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leads physicians to order these cultures in the first place.

In an article with good news, Madlon-Kay[7] found that the use of "opt-out" orders, the involvement of nursing and physician staff, and agreement on certain processes resulted in increased provision of appropriate clinical services in a nursery. Readers who understand the difficulties that lay behind these changes will be interested in this article's details about how Madlon-Kay's institution accomplished these outcomes.

In a study that looked at the use of some aspects of motivational interviewing,[8] obese patients whose physicians made reflective statements felt more autonomous, and thus more confident in their ability to make personal lifestyle changes. Patients whose physicians were more empathic reported more satisfaction. Unfortunately, the use of these two techniques was generally low. The authors also provide useful examples.

However, with colon cancer screening, Fenton et al[9] found that the mere discussion of the subject by the physician during an office visit was associated with higher rates of completed screening, regardless of whether the physician addressed specific behavioral constructs. Maybe one answer to behavior change is to incorporate some flash cards and games, as noted in the research letter by McGaffey et al.[10] With a few minutes, physicians (mostly residents) could easily incorporate office-based exercise counseling for 9- to 12-year-old children, and they reported being more comfortable about so doing in the future.

## Cancer Screening and Follow-up

More advanced cancers are diagnosed in individuals from Appalachia, which seems to result from lower rates of colon cancer screening by sigmoidoscopy or colonoscopy and breast cancer screening by mammogram.[11] Women with diabetes had lower rates of mammography screening, though not of clinical breast examination. The differences in screening rates were approximately 10% to 15%.

Family physicians often feel they lose track of patients after a cancer diagnosis. However, Dobie et al[12] found that elderly colorectal cancer patients had slight increases in their number of primary care visits after diagnosis. Thind et al[13] reported that approximately four out of five breast cancer patients were extremely satisfied with the care provided by their family physicians. Being willing to answer patient questions and doing so in an understandable manner were key to patient satisfaction.

Wilkinson et al[14] noted that women with intellectual disabilities have lower rates of cancer screening and found that certain aspects about the individual, their living situation, and support are associated with whether or not they receive screening. This research provides ideas to increase rates for screening.

## Other Topics

Deyo et al[15] used electronic medical records to identify what happens to patients after their first office visit for back pain. Many patients received short-acting narcotics, particularly near the time of the first visit. Approximately 20% of the patients went on to chronic use of narcotics. Those patients with chronic use of narcotics had high levels of comorbidity, with more than half being obese and/or smokers. These data also suggest physicians' clinical inertia for moving from short-acting to long-acting types of narcotics. Perhaps an arbitrary time frame would help: if patients are still taking narcotics at 2 months, wean them or switch to long-acting medications, with patient agreement reflected in a signed narcotics contract. There are many interesting twists to these difficult stories.

With a discriminating eye for the literature, Planta[16] reviewed the evidence for the use of sunscreens to prevent malignant melanoma, particularly beyond a specific latitude. She found the extant literature wanting, with better evidence to encourage prevention of sun burns than generalized recommendations for sunscreen use, which for most patients is intermittent at best.

Do increasingly higher levels of exercise improve bone mineral density among young women? We know that some young women who exercise heavily stop menstruating and have low bone density. Arasheben et al,[17] using meta-analytic techniques, found that increasing intensity of exercise was associated with increasing bone density. More details about this relationship are provided in the article.

Herpes, a potentially fatal illness in newborns, often can be identified and treated before serious consequences occur. White and Magee[18] provide a case example with key findings and actions to take. In another brief report, Sutherland et al[19] provide a reminder to ask, Is this mass as superficial as it seems, or could it be deeper and more difficult to remove?

On another note, a rural medical school program that was designed to encourage physicians to enter rural practice was successful for women as well as men.[20] With family physicians so critically needed in rural America, we are glad to see women physicians are an important part of the solution to that pressing problem.

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