

## Point-of-Service Reminders for Prescribing Cardiovascular Medications

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**Objectives:** To provide physicians with evidence-based recommendations for care at the point of service, using an automated system, and to evaluate its effectiveness in promoting prescriptions to prevent cardiovascular events.

**Study Design:** Randomized controlled trial.

**Methods:** Patients at risk for cardiovascular events who might benefit from angiotensin-converting enzyme inhibitors or 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statins) were identified from electronic data in a managed care organization and randomly assigned into 2 groups. Physicians seeing outpatients in the intervention group were faxed a sheet with pertinent patient data, including a recommendation to prescribe the indicated medication. In the control group, the data sheet did not include the recommendation. Dispensed prescriptions were compared between groups.

**Results:** More than 4000 visits were observed for each medication type. Angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers were dispensed in 7.1% of visits in the intervention group versus 5.7% in the control group ( $P = .048$ ) following the first patient-physician encounter. No significant difference was observed for statins (intervention, 8.1% vs control, 7.7%). Data for all patient-physician encounters and both medications were combined in logistic regression analysis. The odds ratio was 1.19 for a dispensed prescription in the intervention group and 1.54 for 2 or more visits versus 1 visit.

**Conclusions:** An automated system that provides pertinent data and tailored recommendations for care at the point of service modestly increased prescription dispensing rates. Targeting patient-provider encounters to change provider behavior is challenging; however, even small effects can produce clinically important results over time.

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Preventive care, among other services, is not delivered optimally in the United States.<sup>1-3</sup> Knowledge about what to do often surpasses performance by a wide margin. Translating research into practice is difficult, especially for chronic disease care, in which patients and providers are influenced by many factors that make adoption of new practices difficult.<sup>4-7</sup> All too often, clinical trial interventions require intensive services that may not be practical in many healthcare settings, and guidance on implementing these interventions is lacking.<sup>7</sup> Some understanding exists of the features of research<sup>7</sup> (eg, broad applicability) and inno-

vations<sup>8</sup> (eg, simplicity) that improve the practical application of research results.

Information technologies have been recommended by the Institute of Medicine<sup>9</sup> as a means to improve healthcare in many ways. Clinical information systems may reduce barriers to preventive care and errors of omission by providing timely information and decision-making support in busy practice settings.<sup>10,11</sup> Experience suggests that some applications to support decision making, such as computerized reminders, are more effective than others.<sup>12,13</sup> Published evaluations of computerized reminders often report effectiveness, depending on the type of prompt, setting, and service targeted.<sup>13-17</sup> Although successful interventions are not the rule even in experienced hands,<sup>18</sup> areas of demonstrated effectiveness include drug prescribing and dosing, preventive care (generally primary prevention, including inpatient prevention services),<sup>19</sup> and some other aspects of care but not diagnosis. Decision support systems in which patient data are matched to a computerized algorithm for generating patient-specific recommendations can improve care but have not been convincingly demonstrated as effective in chronic disease management and secondary prevention.<sup>16,17,20</sup>

The objective of this study was to determine the effectiveness of delivering patient-specific reminders for prescriptions to physicians at the point of service. A clinical information system was used to generate recommendations for cardiovascular medications in a large population of high-risk patients. Several characteristics of the intervention contribute to potential effectiveness and generalizability. First, the system was conceived by practicing physicians as a workable approach to prob-

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lems they face in processing information and remembering guidelines while delivering care. Second, the intervention is a form of computerized reminder, which is a comparatively strong means of translating guidelines into practice. Third, patient-specific recommendations for care were based on convincing evidence demonstrating reduced cardiovascular disease (CVD) events. Fourth, the system was already well established in a large healthcare organization, demonstrating its feasibility in similar settings. To our knowledge, similar reminder systems tested across a large healthcare system have not been reported.

## METHODS

In brief, an intervention group composed of physicians seeing outpatients with diabetes mellitus at risk for CVD events received recommendations to start an indicated medication, while a control group received no recommendations (ie, usual care). The medications recommended were angiotensin-converting enzyme inhibitors (ACEIs) and 3-hydroxy-3-methylglutaryl coenzyme A reductase inhibitors (statins). Rates of dispensed prescriptions were compared between study groups. The Southern California Kaiser Permanente Institutional Review Board approved the study. Informed consent was waived for patients. Southern California Kaiser Permanente Medical Group physicians were informed of the study, were given study investigator contact information, and could opt out of the study.

### Participants

Participants came from Southern California Kaiser Permanente, which is an integrated, group-practice, prepaid health plan that provides comprehensive medical services to more than 3 million members in southern California. Family practice, internal medicine, cardiology, endocrinology, and nephrology physicians were potential participants. Physicians became subjects if they saw an eligible outpatient during the study.

Patients eligible for the ACEI recommendation were men and women aged 55 to 80 years with no dispensation of an ACEI or angiotensin II receptor blocker (ARB) in the past 12 months and with (a) diabetes mellitus with high-density lipoprotein cholesterol levels less than 36 mg/dL ( $< 0.93$  mmol/L) or low-density lipoprotein cholesterol levels greater than 130 mg/dL ( $> 3.37$  mmol/L) or (b) atherosclerotic vascular disease. Men and women aged 55 to 80 years were eligible for the statin recommendation if they had no statin or other lipid-lowering drug dispensed in the past 6 months and had diabetes mellitus with low-density lipoprotein cho-

lesterol levels greater than 100 mg/dL ( $> 2.59$  mmol/L). These target populations represented an expansion of previous health plan guidelines for ACEI and statin use following the results of the Heart Outcomes Prevention Evaluation study,<sup>21</sup> published in 2000, and the Heart Protection Study,<sup>22</sup> published in 2002. The statin recommendation depended on a shorter, 6-month period without a dispensation because the medical group had decided to identify patients more aggressively by the time of the statin recommendation, which started 7 months after the ACEI recommendation.

Established case-identification databases provided information on eligible patients, using data from 1997 to the start of each intervention. Patients with diabetes mellitus were identified by 1 or more inpatient *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* codes for diabetes mellitus, 2 or more outpatient *ICD-9-CM* codes for diabetes mellitus, a hemoglobin A<sub>1c</sub> level greater than 7.5%, a record of dispensed oral hypoglycemic agents or insulin, or direct entry into the system by care providers. Based on prior medical chart review, the sensitivity of the database is estimated to be at least 93% and the positive predictive value is about 95%. Patients with atherosclerotic vascular disease were identified by inpatient *ICD-9-CM* codes indicating atherosclerotic vascular disease (eg, acute myocardial infarction), procedure codes for coronary artery revascularization, 2 or more outpatient *ICD-9-CM* codes indicating atherosclerotic vascular disease or 1 outpatient *ICD-9-CM* code with 3 or more nitrate dispensations in a 3-year period, or direct entry into the system by care providers. This database is estimated to have a positive predictive value of about 83% based on several validity investigations, including medical chart review.

### Intervention

The health plan has a multifaceted program for population healthcare management of chronic disease that relies heavily on chronic disease case-identification databases. An important component of this program is the care management summary sheet, which contains pertinent data for the care of patients with chronic disease. Single-page sheets are faxed from a central location the morning of a scheduled outpatient appointment and attached to the medical chart. Providers are targeted to receive the sheet if they are among medical specialties that provide outpatient preventive care; however, some surgical specialties request the fax because the data summary is deemed useful.

These care management summary sheets were conceived by physician leaders and first implemented in late 1998 as an efficient means of providing clinicians with up-to-date, pertinent information for decision

making. These physician leaders recognized that it takes time to gather data, providers often forget to check for clinically recommended prescriptions, and confusion often results when guidelines are applied in particular situations.<sup>23</sup> Patient-specific recommendations were included to remind providers to take action and to assist in decision making. Over time, experience using the system has led to an emphasis on a limited number of short and directive recommendations. This approach assumes that providers know about clinical guidelines but do not always remember to incorporate this knowledge into practice.

The care management summary sheet identifies the patient and lists his or her chronic disease diagnoses, with estimates of disease severity as determined by risk algorithms (an example sheet is available from the author). Separate tables list the latest dispensed medications and pertinent laboratory data (eg, hemoglobin A<sub>1c</sub> levels) with associated dates. The dates and primary diagnoses of the most recent hospital and emergency department visits are included. A list of recommendations for testing, medications, advice, or referrals (eg, to education classes) is included on each sheet. Recommendations are derived from periodically updated clinical practice guidelines. Typically, there are 2 to 3 such recommendations per patient. Although the recommendations are considered the most important part of the care management summary sheet, the effectiveness of the recommendations had not been tested until the present study.

We tested the effectiveness of 2 new recommendations for care supported by a clear evidence base as indicators of the effectiveness of this approach for prompting prescriptions. The recommendations were begun at different periods because of the natural time frame of organizational decisions and actions. Physicians were sent care management summary sheets for targeted encounters with eligible patients. The sheets included the new recommendation message or did not include the new message but were otherwise the same. Messages not related to the study, such as recommendations to get a hemoglobin A<sub>1c</sub> test, were continued. Targeted encounters were those between eligible patients and providers, following procedures that were independent of the study. After the study ended, the recommendations were included on all data sheets for targeted encounters.

The message for the ACEI-targeted population was “high CVD risk: start lisinopril (target, 10-40 mg/d).” For the statin-targeted population, the message stated “high CVD risk: start lovastatin 10 mg/d” if the last serum creatinine measurement was 2.0 mg/dL or higher and “high CVD risk: start lovastatin 40 mg/d” if the

last serum creatinine measurement was less than 2.0 mg/dL or if measurement results were not available in the past 12 months.

Whenever significant changes to the care management summary sheet are made, all physicians are informed by mail. Medical group leaders in local service areas are asked to notify providers by discussing these changes at local group practice meetings. For this study, physicians were informed by mailed fliers that new recommendations for ACEIs and statins were forthcoming and that the effect of the recommendations would be studied. Before and independent of these events, information on the Heart Outcomes Prevention Evaluation study<sup>21</sup> and the Heart Protection Study<sup>22</sup> had been presented in local service areas by population healthcare physician “champions.” In addition, all health plan providers receive hard copies of clinical practice guidelines, which are often discussed in local and regional conferences and seminars and are also available on an intranet.

### Outcomes

Outcomes were dispensed prescriptions of an ACEI or ARB and a statin within 2 weeks after a visit by an eligible patient. Prescriptions were identified by computer from the health plan’s pharmacy database using general product identifier codes and product name recognition. If an ARB was started, it was considered equivalent to starting an ACEI. About 92% of health plan members have a prescription benefit, and it is believed that most members fill prescriptions at health plan pharmacies, which is required for the benefit.

### Randomization

Less than 2 weeks before the start date for each medication recommendation, patients whose data would result in a message were randomly assigned by computer equally into the intervention and control groups. For the ACEI group, patients with diabetes mellitus, atherosclerotic vascular disease, and both conditions were randomized equally between intervention and control groups. If a patient visited a provider more than once during the study, the assignment was retained for each visit. Physicians could see patients in the intervention and control groups. Random assignment of patients rather than providers was chosen because by using this method all providers had equal access to information and comparisons between the intervention and control groups focused on the reminder and prompting function of the recommendations, which was their primary purpose.

### Sample Size

A minimum sample size was calculated by expecting an increase from 15% to 20% in drug dispensation rates.

Using the significance level of  $P < .05$ , equal-sized groups, a 2-sided test of proportions, and 90% power required 2504 unique patient-provider encounters. This number was estimated to be achievable within 3 weeks for the ACEI recommendation and within 4 weeks for the statin recommendation. It was thought to be important to continue the intervention for at least 4 weeks to allow sufficient time for targeted physicians to be exposed several times to the new recommendations and to become fully cognizant of the change. The ACEI intervention lasted 4 weeks, and the statin intervention, which occurred 7 months later, lasted 6 weeks to have similarly large sample sizes.

**Statistical Analysis**

The effects of randomization were assessed with  $t$  tests, Fisher exact tests, and the binomial test. The basic unit of analysis was the patient-physician dyad that occurred at each clinic visit. Dispensation rates for each medication following the first encounter of a patient with a physician were compared between the intervention and control groups using Fischer exact test with 2-sided hypotheses. The data for both medication recommendations were combined and similarly analyzed to assess the effectiveness of the intervention more generally. Differences in dispensed prescriptions were examined between primary care and specialty care. An homogeneity of odds ratio test was used to compare the differences between primary care and specialty care in responsiveness to the intervention. A patient-level analysis that combined both medication recommendations and controlled for the number of patient visits was performed using logistic regression. All faxes were analyzed even if the transmission record indicated that the fax was not received. Data were analyzed using SAS version 8 (SAS Institute, Cary, NC) and StatXact version 5 (Hearne Scientific Software LLC, Chicago, Ill).

**RESULTS**

There were 31 015 patients randomized into the study who were not taking ACEIs or ARBs and 20 185 randomized patients not taking statins. To place these numbers in context, among patients who were considered eligible for medica-

tions, 63.9% were already taking ACEIs or ARBs at the start of the study, and 53.2% were already taking statins or other lipid-lowering drugs. **Table 1** summarizes the characteristics of patients who were randomized and who visited study providers. There were 8557 patients and 1089 physicians who received the study intervention. No physicians asked to be excluded from participation in the study. Ninety-three percent of all faxes were recorded as received by the targeted fax machines.

**Angiotensin-Converting Enzyme Inhibitor Message**

For the ACEI portion of the study, there were 4678 unique patient encounters with 975 different primary care and specialty physicians during 4 weeks starting in July 2002. In the intervention group, 164 (7.1%) of 2311 patients were dispensed an ACEI or ARB. In the control group, 134 (5.7%) of 2367 patients were dispensed the medications (**Table 2**). The difference, 1.4%, is just barely significant ( $P = .048$ ).

**Statin Message**

For the statin message, there were 4183 unique patient encounters with 941 different primary care and specialty physicians during 6 weeks starting in February 2003. In the intervention group, 171 (8.1%) of 2103 patients were dispensed a statin (**Table 2**), and in the control group 160 (7.7%) of 2080 patients were dispensed a statin. The 0.4% difference between groups is not significant ( $P = .61$ ).

**Combined Results**

Data for both recommended medications were com-

**Table 1.** Characteristics of Study Patients\*

Characteristic	Angiotensin-Converting Enzyme Inhibitor Recommendation			Statin Recommendation		
	Intervention Group (n = 2311)	Control Group (n = 2367)	P	Intervention Group (n = 2103)	Control Group (n = 2080)	P
Age, mean, y	68.0	68.2	.39 <sup>†</sup>	64.9	65.3	.03 <sup>†</sup>
Female sex, %	39.8	39.2	.68 <sup>†</sup>	53.1	54.5	.37 <sup>†</sup>
No. of visits			.85 <sup>§</sup>			.90 <sup>§</sup>
1	2067	2121		1807	1790	
> 1	244	246		296	290	

\*The numbers of patients in the table represent unique study patients in each group with at least 1 provider encounter, which is equivalent to the number of first patient-physician encounters.

<sup>†</sup>t Test for equivalence of means.

<sup>‡</sup>Fisher exact test for equivalence of proportions.

<sup>§</sup>Binomial test for equivalence of proportions of patients with 1 visit.

**Table 2.** Prescription Dispensation Rates After the First Patient-Physician Encounter\*

Recommendation	Intervention Group	Control Group	Difference	P <sup>†</sup>
ACEI or ARB	7.1 (6.1-8.2) (n = 2311)	5.7 (4.8-6.7) (n = 2367)	1.4	.048
Statin	8.1 (7.6-10.2) (n = 2103)	7.7 (6.6-8.9) (n = 2080)	0.4	.61
ACEI or ARB and statin	7.6 (6.8-8.4) (n = 4414)	6.6 (5.9-7.4) (n = 4447)	1.0	.08

ACEI indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker.

\*Unless otherwise indicated, data are given as percentage (95% exact binomial confidence interval).

<sup>†</sup>Fischer exact test with 2-sided hypotheses.

bined (Table 2). The combined dispensation rate for either type of medication was 7.6% in the intervention group and 6.6% in the control group (difference, 1.0%;  $P = .08$ ). Whether in the intervention or control group, visits with specialists were more often followed by a dispensed prescription than visits with primary care physicians (difference, 3.0%;  $P < .001$ ). However, there was no difference between specialists and primary care physicians (odds ratios [ORs], 1.16 and 1.20, respectively;  $P = .92$ ) in the odds of a prescription being dispensed in the intervention versus the control groups. Combined across the intervention and control groups, the overall dispensation rate was 6.7% for patients with 1 visit and 10.3% for patients with 2 or more visits (difference, 3.6%;  $P < .001$ ).

Logistic regression analysis was used to further examine the effect of the intervention on dispensation rates if 1 or more visits occurred, controlling for the number of visits, the medication recommended, and patient age, sex, and past medication use. The number of visits was coded as 1 versus more than 1, because only 1.4% of patients had more than 2 visits during the study. We controlled for known dispensations of ACEIs, ARBs, statins, and other lipid-lowering drugs up to 2 years before the date of the patient visit, excepting the dispensation-free period that prompted the recommendation. To preserve independence, observations on patients who were in both the ACEI and the statin groups were dropped. The combined analysis involved 8557 patients with 1 or more physician encounters.

The OR of dispensing an ACEI, ARB, or statin in the intervention versus the control group was 1.192 (95% confidence interval [CI], 1.01-1.40;  $P = .04$ ); hence, the

recommendation messages increased the odds of a dispensed prescription by 19.2% at any given visit. The odds of a dispensation increased for more than 1 visit versus 1 visit (OR, 1.538; 95% CI, 1.24-2.91 [ $P < .001$ ]); however, an interaction term revealed no difference in trend from 1 visit to more than 1 visit between the intervention and control groups. Prior medication use was associated with an increased odds of a dispensation (OR, 2.25; 95% CI, 1.82-2.79 [ $P < .001$ ]). After controlling for prior use of the medication, the difference

between dispensations of ACEIs or ARBs versus statins was nonsignificant (OR, 0.87; 95% CI, 0.74-1.04). Patient age and sex were not significant predictors of prescription dispensations.

#### Quality Review of Encounters

As part of a quality review, 50 medical charts of patients for whom no ACEI or ARB was dispensed, despite a recommendation to do so, were reviewed. All patients qualified for the medication. Seventeen of these encounters were judged "missed opportunities," while the remaining 33 were deemed "not inappropriate." Examples of encounters that understandably did not result in a dispensed drug include gastrointestinal endoscopy, preoperative consultation, a pacemaker check, an infectious disease consultation, nephrology visits in which an ACEI was contraindicated, a cardiology visit in which the patient had low blood pressure while taking a small dosage of  $\beta$ -blocker, a pulmonology consultation, and a documented prescription that was not picked up.

#### DISCUSSION

The fundamental question evaluated by this study is whether a reminder to providers for evidence-based care that is targeted to the patient, is specifically detailed, and is delivered at the point of outpatient service can change provider prescribing behavior in a large health plan. The system we evaluated demonstrated less than the expected effect. Overall, although the odds of a prescription being filled increased by 19.2% when a recommendation was delivered, the absolute increase in dispensation rates was small at 1.0% (ie, from 6.6% to

7.6%) in the combined analysis. In general, cardiologists, nephrologists, and endocrinologists had higher rates of dispensed prescriptions than primary care physicians but no difference in responsiveness to the recommendation message. Although the study was not designed to test if the intervention worked better or worse over time, there was no evidence that the prompt became more “potent” with repeated member visits.

It is unclear why the implementation of the recommendation was better for ACEIs and ARBs (1.4%) than for statins (0.4%). The explanation may be in part because of the more recent publication of the Heart Protection Study<sup>22</sup> than the Heart Outcomes Prevention Evaluation study<sup>21</sup> and the time it takes to change practice behavior in response to new information. There is no difference between the drugs in copayment for members with a drug benefit and only small differences in charges for members without a drug benefit. Overall, statins were dispensed more frequently than ACEIs during clinic visits, perhaps reflecting more opportunity for improvement (eg, less history of noncompliance) associated with the lower proportion of eligible patients already taking statins. Differences between dispensation rates were reduced after adjustment for prior use of medications in logistic regression analysis. Prior use of medications increased the odds of a dispensation, possibly indicating a lapse in compliance or reluctance to use medications, perhaps because of costs or borderline blood pressure and cholesterol levels.

Although the quality review cannot fully explain the observed dispensation rates, it demonstrated how often this intervention targeted encounters in which the recommended action was not reasonably expected. If dispensations following the ACEI recommendation are adjusted by assuming that two thirds of encounters with no dispensed prescription would not normally result in a prescription, then the response becomes 18.0%.

Patients with 2 or more visits had 53.8% higher dispensation rates than patients with a single visit, although frequent visits during a short period might suggest difficult medical problems; therefore, repeated contact with providers is important. In our study populations, patients had medians of 10 and 12 visits of any kind in a year for the statin- and ACEI-eligible patients, respectively, so the effects of the intervention are expected to accumulate over time. An absolute difference of 1.0% between the intervention and control groups suggests that 100 patient-physician encounters would need the intervention for 1 additional patient to get a prescription. The Heart Outcomes Prevention Evaluation study<sup>21</sup> suggested that 15 high-risk people with diabetes mellitus would have to be treated with ACEIs for about 5 years to prevent 1 major cardiovas-

cular or microvascular outcome, and the Heart Protection Study<sup>22</sup> suggested that 10 to 14 high-risk individuals would have to be treated with statins for 5 years to prevent major vascular disease events.

The primary difference between our study and prior studies is in the application of the intervention to an entire large healthcare system rather than to a single clinical setting, an academic institution, or providers selected and trained to receive the intervention. We believe that this use of clinical information systems is reproducible in other healthcare settings. For example, the HMO Research Network<sup>24</sup> is a consortium of 13 health maintenance organizations with research capabilities, including corresponding data systems, and more than 40 million members. However, many organizations may not have access to updated and comprehensive laboratory, pharmacy, and administrative data that are used to initiate and target a broad array of population healthcare recommendations.

In this study, patients were randomized rather than physicians; therefore, with about 4.5 study visits per provider, each physician was approximately equally exposed to the recommendations. With repeated exposure, physicians probably learn to recognize the need for a prescription without the recommendation. Providers might apply that learning to patients in the control group, thus boosting dispensations in the control group relative to the intervention group. Alternatively, some providers may become dependent on the reminder recommendations and not act when they are absent, thus exaggerating the difference between groups.

If we had randomized the providers in the study, the difference measured between the intervention and control groups would represent not only the reminder effect of the recommendations but also a positive learning effect. Although unlikely to occur in the short term, randomizing providers would not have eliminated potential bias resulting from providers in the control group learning and applying the recommendations based on the experiences of colleagues in the intervention group. By randomizing patients, the difference between groups represents the proportion of encounters in which equally aware providers needed prompting to apply guidelines. The high proportion of eligible patients taking ACEIs and statins before the study supports the contention that providers were already aware of guidelines. Physician leaders thought that it was valuable to assess the intervention using an estimate of the reminder effect, believing it would hold for similar, established therapeutic recommendations.

Although our study patient population was large and likely to be representative of many patients at high risk for CVD, it is possible that our study providers are more

or less responsive to similar interventions than providers in other organizations. A survey of provider perceptions of an earlier version of the care management summary sheet from June 2002 found that 92% of respondents reviewed the data, 56% believed that it prompted them to start a therapy, and 59% rated the overall effectiveness in helping manage patients with chronic disease as good or excellent (vs poor or fair). We do not know details about how providers use the care management summary sheet (eg, always, only if there is time, or if they seek specific information). Data were not collected on whether the sheet was placed on the medical chart. The effectiveness of the intervention is reduced by faxes not received or not placed on the medical chart. We did not collect data on written prescriptions, which are a more direct measure of provider responsiveness to the intervention than dispensed prescriptions. The intervention's effectiveness was not evaluated over the long term. Health outcomes were not addressed; however, the connection between appropriate use of statins, ACEIs, or ARBs and outcomes was the basis for the recommendations studied. Patients misidentified as being at high CVD risk could reduce the responsiveness of physicians. Finally, no cost analysis was done.

We believe that the results of this evaluation are generally informative of the effectiveness of tailored recommendations for medications given at the time of routine outpatient visits. Although the recommendations tested had a small effect at one point in time, the cumulative effect becomes important within a system of longitudinal care with multiple points of patient contact. Moreover, the care management summary sheet has several recommendations for care in addition to those studied and is deemed useful beyond the care recommendations, so its evolution will continue as it is adapted for more effective use. For example, the care management summary sheets are now printed on-site at patient registration rather than being faxed the night before. Systems with flexibility and the potential to evolve and improve are more likely to have continued effects over time and with repeated patient contact.

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