QUERI Quarterly

NEWSLETTER OF THE QUALITY ENHANCEMENT RESEARCH INITIATIVE

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Director's Letter

The Quality Enhancement Research Initiative was the first of its kind – a unique program created to bridge the gap between research and front-line clinical practice. Going into our fourth year, we have made significant strides and are now eager to share what we have learned about translation with others, as well as to benefit from what others have learned in similar endeavors. Thus we have begun to establish important collaborations with several organizations, both inside and outside VHA.

Within VA, we are working with the Office of Quality and Performance on crosscutting translation themes such as guideline development, dissemination, implementation, and evaluation that will result in systematized organizational change. With the VA Office of Information, QUERI is working to provide – through national extraction efforts – data components required by QUERI groups. Outside of VA, the National Cancer Institute has joined with us to support a new QUERI group that targets colorectal cancer (CRC): the second leading cause of death from cancer. Please see our feature article to learn about CRC QUERI's exciting research agenda. We are also working with the Agency for Healthcare Research and Quality on a joint solicitation that will invite researchers to conduct innovative and rigorous research and

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New Colorectal Cancer QUERI Prioritizes Early Detection

Colorectal cancer (CRC) is both a high volume and high-risk disease. CRC ranks second among causes of cancer deaths, accounts for approximately 11% of all new cancer cases, and is the third most common cancer among men and women. The American Cancer Society estimates that more than 135,000 new cases of cancer of the colon and/or rectum will be diagnosed in 2001. But there is good news: the 5-year relative survival rate is over 90% for people whose CRC is found and treated in Stage I. The bad news is that less than 30% of cases are detected in an early stage and only 5% of those people whose CRC is discovered in Stage IV of the disease will survive. Additionally, Stage II and III colorectal cancers are among the costliest cancers to treat. These estimates are especially tragic given the strong evidence that best screening and surveillance practices would substantially reduce the mortality, morbidity, and cost of colorectal cancer through prevention (finding and removing polyps) and early detection (finding asymptomatic cancers while they are surgically curable).[1]

Current screening guidelines suggest that veterans older than 50 years should have a:

- Fecal Occult Blood Test (FOBT) series – once a year,
- sigmoidoscopy – every 5 years, or
- colonoscopy – every 10 years.

The VA Office of Quality and Performance reports that among patients over age 52 who have had at least three VA visits in a given year, a national average of 32% do not receive timely CRC screening. Specific VISNs' failure to screen rates range from 22% to 42% for those patients who are eligible. Unfortunately, the determinants of variation in screening rates are not well understood.

Evidence-based translation projects to address the gap between best and usual screening practices have enormous potential to prevent suffering, reduce morbidity and cancer-related mortality, improve efficiency of resource use, and substantially improve quality of life for a large number of veterans.

Responding to this opportunity is HSR&D's newly established CRC QUERI Coordinating Center based in Minneapolis, MN. Led by Research Coordinator, Michelle vanRyn, PhD, MPH and Clinical Coordinator, John Bond, MD, CRC QUERI will work to promote the translation of research discoveries and innovations into patient care and systems improvements in order to reduce the inci-

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Applying Evidence from Depression Quality Improvement Research to VA

Evidence-Based Quality Improvement (EBQI) is a method for helping health care systems adopt previously tested and successful treatments to improve care. EBQI uses the peer-reviewed medical literature to identify rigorously evaluated system interventions for improving quality. However, few published interventions can be implemented "as is" in diverse care systems – without translation. The goal of EBQI is to integrate the intervention into the policies, procedures, and activities of the adopting care system. A first step in EBQI implementation is to introduce the elements of the intervention to interested care system leaders and achieve consensus on importance and feasibility of intervention elements.[1]

This article discusses the process and results of the Depression Intervention Design (DID) panel that served as the template for EBQI planning in two VA VISNs, 10 (Ohio) and 13 (Upper Midwest). This work is part of the initial phase of the Well-Being Among Veterans Enhancement Study (WAVES), an HSR&D Mental Health QUERI project.

Quality improvement for depression can be achieved by implementing a collaborative care model that includes four elements:

- provider and patient education,
- decision support,
- care management, and
- collaboration between primary care clinicians and mental health specialists.[2]

Research shows that the collaborative care model is cost-effective,[3] but implementation necessitates significant commitment by the health care system. Gaining such a commitment requires that key health care system leaders learn about the evidence base, consider changes required in terms of existing practice and priorities, and decide upon strategies for introducing and maintaining the model in their own medical care settings. The DID was designed to accomplish these goals.

The WAVES DID incorporated expert panel methods that have been used successfully in previous quality improvement efforts.[1] Key stakeholders in the two participating VISNs were identified and invited to participate, including VISN directors as well as primary care, mental health, nursing, and quality improvement leaders. The resulting DID panel incorporated 26 collaborators who met to discuss the collaborative care model.

Panel findings

The DID panel rated the collaboration of mental health care with primary care as the most important goal for depression quality improvement. Important features of the collaboration include:

- availability and coordination of short-term psychotherapy,
- "curbside" or informal consultation with mental health providers,
- emergency mental health care,
- care for PTSD and substance abuse, and
- care for complex patients who do not improve with initial treatment.

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Colorectal Cancer

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dence, late detection, suffering, and mortality from colorectal cancers (CRC) among all veterans.

The first priority of the CRC QUERI will be to identify and implement interventions to promote best CRC screening and colonoscopic follow-up practices. Some important results of CRC's initial objectives include developing:

- Valid, efficient data systems for monitoring variations in CRC screening and quality of CRC treatment, and assessing impact of quality improvement efforts;
- Effective strategies for increasing CRC screening and reducing late detection;
- Systematic reviews and reports on best practices for stage-specific CRC treatment; and
- Culturally sensitive programs targeting patient adherence and provision of culturally appropriate care.

In addition to the primary emphasis on prevention and early detection, enhancing the quality of CRC treatment and end-of-life care is a significant mission for the CRC QUERI Coordinating Center.

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For more information about CRC QUERI, contact Melissa Partin, PhD at (612) 725-2000, ext. 3841 or by e-mail at melissa.partin@med.va.gov.

1. Lieberman DA and Weiss DG. One-time screening for colorectal cancer with combined fecal occult-blood testing for examination of the distal colon. NEJM 2001, August 23; 345(8):555-60.

Promoting Adherence to Lipid Management Guidelines

Ischemic heart disease is the leading cause of death in the United States for both men and women, and is one of the most frequent reasons veterans are admitted to VA hospitals. Secondary prevention for IHD focuses on reducing the risk of recurrent heart attacks, hospitalization, and other undesirable outcomes. One of the primary things we can do to reduce these risks is to increase the number of veteran patients whose low-density lipoprotein cholesterol (LDL-c) is at or below the guideline recommended goal of 100 mg/dL.

In the April issue of *QUERI Quarterly*, we reported on IHD QUERI's efforts to address the gap between guideline recommendations and provider treatment. Working to further this goal, IHD QUERI conducted a study to promote secondary prevention among patients with IHD, and to explore the effect of those interventions on patient outcomes. Secondary prevention interventions in this study focused on management of LDL-c.

Included in the study were all IHD patients who received ongoing and consistent care in primary care clinics or cardiology through one of the eight facilities participating in the project-throughout the period of observation. Qualitative data were collected in interviews with the clinicians that had some role in the planning or implementation at each facility to explicate the intervention process.

Each facility in VISN 20 was classified into one of four categories of interventions: lipid clinic, point of care reminder, preprinted order templates for lipid panels, or combined audit/feedback intervention (audit/feedback and pharmacist lipid management or audit/feedback and patient education). These intervention types were then compared in improving lipid measurement and management outcomes.

Two process measures and one outcome measure to assess the impact of the interventions on risk of secondary complications in patients with known IHD were used. The first process measure is the proportion of patients tested for LDL-c at each facility. The second process measure is the treatment with lipid lowering agents (LLAs). The outcome measure is the proportion of patients who were at the National Cholesterol Education Panel (NCEP) recommended goal for IHD (LDL-c ≤100mg/dl).[1]

Of the 8550 patients continuously receiving care over the project period:

- 17.5% were in facilities with lipid clinic interventions,
- 12.0% were in facilities that developed POC reminders,
- 33.1% were in facilities using combined audit/feedback interventions, and
- 37.4% were in facilities with order template interventions.

The lipid clinic sites tested significantly greater numbers of IHD patients for LDL-c than the audit/feedback sites ($p < .0001$). The POC reminder sites improved their rates of testing by 12%, and order template sites improved their rates by 8%; both of these intervention types were associated with significantly higher rates of improvement in LDL measurement than the audit/feedback sites over the 22-month project period ($p < .0001$).

LLA treatment rates at all facilities steadily improved during the study period. Rates of improvement for lipid clinics, POC reminders, order templates, and combined audit/feedback interventions were 8%, 9%, 10%, and 7% respectively.

In terms of the proportion of IHD patients at guideline recommended goal, the order template facilities performed significantly better ($p = .008$) than the audit/feedback facilities. Order template facilities increased the proportion of patients at goal by 12%, a significantly greater improvement than the combined audit/feedback facilities, which had an overall improvement of 7%. No other

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QUERI Quarterly is a quarterly publication of the Office of Research and Development's Health Services Research and Development Service. This newsletter discusses important issues and findings regarding the Quality Enhancement Research Initiative. QUERI focuses on the following nine conditions due to their high volume and/or high risk among VA patients: cancer, chronic heart failure, diabetes, HIV/AIDS, ischemic heart failure, mental health, spinal cord injury, stroke, and substance abuse. *QUERI Quarterly* is available on the web at www.va.gov/resdev/prt/pubs_individual.cfm?webpage=pubs_queri_quarterly.htm. For more information or to provide us with feedback, questions or suggestions, please contact:

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Lipid Management

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differences in this outcome measure were statistically significant.

Barriers and Facilitators

Respondents often described similar barriers and facilitators, even though facilities varied widely in size, type (primary or tertiary), intervention(s) selected, and the number and types of clinical and support staff available for the interventions. Among the barriers mentioned more commonly were: lack of team process, poorly defined roles and responsibilities among team members, lack of buy-in from providers, lack of communication, lack of time set aside to do prevention activities, and lack of management support. Facilitating factors included such things as an efficient computerized patient record system, a multidisciplinary intervention team, conscientious provider staff at the facility, and enthusiastic intervention teams.

The project reported here was a brief, rapid-impact pilot intervention evaluation, designed to examine the effects of interventions selected by the facilities themselves. This pilot project has shown that certain interventions (lipid clinics, order templates, and POC reminders) can positively affect process variables compared to other interventions (audit/feedback).

Sandra Pineros, PAC, MPH, Nancy Sharp, PhD, and Anne Sales, PhD

1. Expert panel on detection, evaluation, and treatment of high blood cholesterol in Adults: Executive Summary of the third report of the National Cholesterol Education Program (NCEP) [Adult Treatment Panel III]. *JAMA* 285:2486-2497, 2001.

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Depression Improvement

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In terms of the other aspects of a depression care model, DID participants believe that detection of depression should focus on screening for major depression and dysthymia, that non-MD primary care staff should carry out screening, and that the screening method should integrate with the Computerized Patient Record System (CPRS). Panelists also consider involvement or support from Veterans Service Organizations to be highly desirable.

Participants were divided on whether a nurse case manager should be located on-site or could function at the VISN level off-site, but panelists did endorse a mental health specialist as the supervisor for the case manager. Finally, panelists rate support from senior leaders, prior approval of project time for participants from these leaders, and workload credit for collaborative care activities as critical for the long-term goals of integrating high quality depression care into usual care practices.

These priorities from VA clinical leaders in the two VISNs, and from the work-groups derived from the panel, have become the foundation for the design of a multiple VISN depression improvement approach. This approach translates and adapts research on effective models of care for depression for use in VA settings.

Lisa Rubenstein, MD, MSPH, Edmund Chaney, PhD, and Robert Petzel, MD

1. Rubenstein LV, Fink A, Yano EM, Simon B, Chernof B, Robbins AS. Increasing the impact of quality improvement on health: an expert panel method for setting institutional priorities. *Jt Comm J Qual Improv*. 1995;21:420-432.

2. Hedrick SC, Chaney EF, Liu CF, Felker BL, Bagala R, Paden GR. Process of Care in Innovative and Traditional Treatments for Depression in VA Primary Care: Reallocating Resources. *HSR&D Service 19th Annual Meeting*. Washington, DC: 2001.

3. Wells KB, Sherbourne C, Schoenbaum M, Duan N, Meredith L, Unutzer J, Miranda J, Carney MF, Rubenstein LV. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial [In Process Citation]. *JAMA*. 2000;283:212-220.

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Submissions

Please submit articles, updates or other information of interest to our readers by **Friday, February 1, 2002** for publication in our March 2002 issue. Submit to Diane Hanks at diane.hanks@med.va.gov.

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evaluation projects related to the translation of research findings into measurable improvements in quality, patient safety, health care outcomes, and access to care. This collaborative effort will provide the opportunity to compare and contrast translation efforts within and across different systems of care.

The translation of research into practice requires blazing a trail that is full of challenges and opportunities. We look forward to working with all of those who bring their talent and expertise to this exciting new field.

John G. Demakis, MD
Director, HSR&D