



VA HEALTH SERVICES RESEARCH & DEVELOPMENT (HSR&D)
 CENTER OF EXCELLENCE
 FOR THE STUDY OF HEALTHCARE PROVIDER BEHAVIOR

NEWSLETTER

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HCFA HEALTHY AGING PROJECT

Overall life expectancy—and life expectancy at age 65—have increased dramatically in the U.S. during the past century. Improvements in medical care (especially antibiotics and public health), health habits (exercise, diet, smoking avoidance) and other preventive measures (blood pressure control, early disease detection) have all contributed to this increase, along with expanded access to medical care through the Medicaid and Medicare programs.

Although the health status and functioning of older persons have improved in parallel with life expectancy increases, chronic illnesses remain common, and the overall prevalence and burden of these illnesses and associated impairments among the elderly have *increased*, due to significant growth in the size of the elderly population. Thus, larger numbers of Medicare beneficiaries are living longer, and developing functional losses associated with the multiple health problems common among the elderly. In fact, four of five older Americans have at least one chronic disease; one quarter are hampered in their basic activities of daily living by one or more such conditions. Yet evidence suggests that many of these limitations could be prevented through greater use of existing, effective preventive practices and services. More complete implementation of such measures would lead to improvements in the health of the elderly popula-

tion, with possible financial benefits through decreased utilization of costly medical services as well.

The goal of the Healthy Aging Project, a RAND-VA collaboration led by Center researchers Laurence Rubenstein, MD and Paul Shekelle, MD, PhD, is to identify effective interventions for promoting health and preventing functional decline in older populations, to identify strategies to enhance deployment of these interventions, and to draw inferences relevant to the Medicare program. The five-year study is funded by the Health Care Financing Administration (HCFA); the project team also includes Center researchers Lisa Rubenstein and Brian Mittman. The study's first phase involves identifying and synthesizing evidence from the literature on health promotion and disease prevention interventions. In the second phase, the study will test two behavioral risk factor reduction interventions in managed care and fee-for-service Medicare settings. The researchers hope to learn the best ways to intervene at the beneficiary, provider and community levels to influence behavioral risk factors and promote healthy aging in the context of the Medicare program.

The study's first evidence synthesis report examined interventions to improve the utilization of existing Medicare-covered clinical preventive and screening

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CENTER MISSION

To promote better health and healthcare for veterans through better understanding of healthcare provider behavior, the factors that influence it, and the health systems interventions that will improve it.

PATIENT, PROVIDER, AND TREATMENT FACTORS ASSOCIATED WITH POOR QUALITY CARE FOR SCHIZOPHRENIA

Schizophrenia is a chronic, disabling disorder that occurs in about 1% of the population. Most treatment for schizophrenia is publicly funded, and the VHA is a major provider. Available treatments include antipsychotic medications which, when appropriately used, result in substantial improvement in symptoms, quality of life, and functioning. However, the care provided to patients with schizophrenia is frequently of poor quality. Outcomes in general practice settings are much worse than in research and demonstration projects providing state-of-the-art care; recent studies have found that more than a third of patients receive inappropriate medication management, and over half do not receive needed psychosocial care. Efforts to improve the quality of care are clearly needed, requiring data and insights to help identify the types of patients at highest risk for poor quality care, as well as the organizational and pro-

vider factors associated with such poor quality care.

To provide these data, Alexander Young, MD (Center investigator at the VA West LA Healthcare Center, and Associate Director of the VISN 22 MIRECC), and two VA and RAND colleagues randomly sampled 224 patients in treatment for schizophrenia at one VA mental health clinic and one non-VA public mental health clinic. They evaluated appropriateness of medication management using data from patient interviews and medical record abstractions. Multivariate regression was used to study the effect of patient and treatment factors on treatment quality, controlling for provider factors. Factors examined included number of prior hospitalizations, race, gender, age, compliance with treatment recommendations, knowledge regarding treatment, insight, use of illicit substances, family in-

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HCFA Healthy Aging Project *(Cont. from page 1)*
services—mammography, pap smear, colon cancer screening, and influenza vaccine and pneumococcal vaccines. MEDLINE, a specialized register of relevant studies maintained by the Cochrane Effective Practice and Organization of Care Review Group, prior systematic reviews, and the Medicare Health Care Quality Improvement Project database were searched for relevant studies. Studies were required to: 1) assess interventions to increase use of any of the five preventive services in adults; 2) employ a randomized clinical trial design, a controlled clinical trial, a controlled before and after study, or an interrupted time-series; and 3) report outcomes as the receipt of the service. Two reviewers independently extracted data about study characteristics and outcomes from unmasked articles. Intervention components to increase the use of services were classified as reminder, feedback, education, financial incentive, regulatory and legislative action, organizational change, or mass media campaign.

Of 552 abstracts and articles identified, 187 were selected for inclusion. Meta-regression models were developed for immunizations and each cancer screening service to assess the effect of interventions. Adjusted odds ratios for organization change

interventions varied from 2.65 to 18.8, for patient financial incentives from 2.22 to 3.57, and for patient reminders from 1.84 to 3.73; the adjusted odds ratios for patient education varied from 1.31 to 2.26 and for feedback from 1.11 to 1.49. Interventions were more effective if they used collaboration or teamwork and if they were designed based on theory or needs assessment. The researchers concluded that organizational change, patient financial incentives, and patient reminders are more effective than patient education or provider feedback at improving the use of immunizations and cancer screening services in adults.

The project's second evidence synthesis report will analyze the effectiveness and methods of implementation for several behavioral risk factor interventions under consideration for coverage under Medicare because of their potential benefit to older Americans, including exercise, smoking cessation, falls prevention, self-management of chronic disease, and health risk appraisals.✱



RISK FACTORS FOR HOSPITALIZATION IN VETERANS WITH ABDOMINAL PAIN

Abdominal pain is a common complaint, with associated disorders ranging from benign self-limited conditions to serious ones requiring immediate hospitalization. Unfortunately, few explicit process-of-care criteria are available for rapid identification and evaluation of patients at risk for serious abdominal pathology. Donna Washington, MD, MPH (VA West LA Healthcare Center), recently completed a study designed to identify risk factors for hospitalization of patients seeking care for abdominal pain, in order to guide triage processes for the timing and intensity of their initial management. She used an evidence-based modified Delphi process in which a 9-member multidisciplinary physician panel identified clinical factors that may be associated with increased risk for serious abdominal pathology. VA ambulatory care triage nurses prospectively assessed the presence of these risk factors in patients seeking care for abdominal pain. All hospitalizations within 7 days were identified. Odds ratios [OR] and 95% confidence intervals [CI] were determined for risk factors present in more than 5 patients. Logistic regression was performed using as predictors risk factors associated with hospitalization at $p < .10$.

Of the 858 patients screened, 169 (19.7%) were hospitalized. Risk factors for hospitalization included (OR; 95% CI): vomiting (OR 2.4; 1.7 – 3.4), hematemesis (OR 2.9; 1.1 – 7.8), symptomatic orthostasis or an inability to maintain hydration with oral intake (OR 2.6; 1.8 – 3.8), surgery of any type within the prior 2 weeks (OR 4.1; 1.0 – 16.5), cirrhosis (OR 3.3; 1.7 – 6.5), pancreatitis (OR 1.8; 1.0 – 3.4), injection drug use within the prior 1 year (OR 2.6; 1.8 – 3.8), abnormal vital signs (temperature ≥ 101.3 , systolic BP < 100 or > 200 , diastolic BP > 110 , pulse < 50 or > 100 , respiratory rate > 24) (OR 2.9; 2.0 – 4.3) and patient age ($p = .046$). Factors that were not significant were: pain location, melena by patient report, current immunosuppressive medication use, active treatment for a malignancy, a history of end-stage renal disease, sickle cell anemia, malignancy, diabetes, inflammatory bowel disease, HIV disease, cardiovascular disease, or abdominal surgery. In logistic regression, age (OR 1.02; 95% CI 1.01 – 1.04 for each 1 year increment), symptomatic orthostasis (OR 1.9; 1.1 – 3.0), surgery within the prior 2 weeks (OR 4.8; 1.1 – 20.1), injection drug use within the prior 1

year (OR 2.3; 1.4 – 3.8), and abnormal vital signs (OR 2.3; 1.4 – 3.6) were independent predictors of hospitalization. Hospitalization rates were 31% for those reporting any of the independent predictors, 11% for those with clinical factors other than the independent predictors, and 3% for those without any of the clinical factors that were identified by the panel.

Dr. Washington concluded that three risk strata are appropriate for classifying ambulatory patients seeking care for abdominal pain. Assignment to a stratum can be performed using a succinct set of history and physical examination findings that are available to a triage nurse. Adoption of this process would achieve brevity in identifying high risk patients, without sacrificing sensitivity in identifying all patients at risk for hospitalization. This may be safer and more efficient than the implicit triage methods that are currently in widespread use.*

VARIATIONS AND CONFLICTS IN CLINICAL PRACTICE GUIDELINE RECOMMENDATIONS: SOURCES AND IMPLICATIONS

Development and dissemination of clinical practice guidelines represent an important strategy for medical societies, government agencies, and other public and private bodies seeking to improve the quality of healthcare and to enhance uniformity of clinical practice. In recent years, the number of published guidelines has expanded considerably, resulting in the availability of multiple overlapping guidelines in many clinical areas. Although redundancy and duplication are not necessarily harmful, guideline users and others often note inconsistencies and conflicts in guideline recommendations, suggesting problems in their evidence base, development methods or other features. Such conflicts may lead to inconsistencies and gaps in healthcare delivery, particularly for patient populations cared for by multiple specialties. To explore these issues, former Center VA Ambulatory Care fellow Eliot

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PHYSICIAN REFERRAL CHOICES IN THE MANAGEMENT OF PATIENTS WITH NEUROLOGICAL CONDITIONS

With the emergence of managed care and gatekeeping, understanding the preferences of specialists and primary care physicians (PCPs) regarding specialists' involvement in the care of patients is central to concerns about quality of care. Dr. Kari Swartztrauber, Center VA Ambulatory Care fellow (VA West Los Angeles Healthcare Center), and colleagues compared neurologists' preferences and primary care physicians' (PCP) intentions regarding specialist involvement in the management of Parkinson's disease, transient ischemic attack (TIA) and dementia.

A stratified random sample of family physicians, general internists, and neurologists from the nine states having the highest penetration of managed Medicare was drawn from three databases: the AMA Physician Masterfile, ACP-ASIM membership files and AAN membership files. Physicians received a 20-minute survey by mail, containing three clinical scenarios, each followed by options for a PCP to either manage alone, curbside, or refer to a specialist. Practice characteristics, knowledge, and utilization management techniques, including financial incentives, were also assessed.

The overall response rate was 60% with 321, 367, and 299 completed surveys obtained for each specialty. Internists' and family physicians' intentions to manage without a referral differed from neurologists' preferences for a PCP to manage without a referral: Parkinson's disease (54% of internists and 60% of family physicians vs. 10% of neurologists, $p < 0.001$), TIA (63% and 54% vs. 8%, $p < 0.001$) and dementia (80% and 71% vs. 5%, $p < 0.001$). Internists were more likely than family physicians to express an intention to manage without a referral for the TIA and dementia scenarios (p 's < 0.05). Bivariate analyses of factors influencing choices for specialty involvement revealed that, across all three scenarios, more PCPs in staff model HMOs (35%) intended to curbside than PCPs in all other practice settings (11%) (p 's < 0.001). On bivariate analysis, none of the utilization management predictor variables (capitation, individual risk pools, withholding, profiling) predicted whether a PCP would manage the patient alone. PCPs who did not know or were unsure of recommended clinical practice for the three scenarios were less likely to manage the patient alone than PCPs who had

correct knowledge (p 's < 0.05).

Given growing restrictions on patient access to specialists, large differences between PCP and neurologist preferences regarding specialty involvement in care for common neurological conditions is a significant policy concern. Further research to determine optimal roles for specialists in managing common patient conditions is required.*

Schizophrenia (Continued from page 2)

involvement in care, frequency of treatment visits, and social functioning.

The researchers found that provider, patient, and treatment factors were each associated with variation in the provision of poor quality care. The two clinics differed significantly in the proportion of patients receiving poor quality care (44% vs. 31%, $p = 0.04$). There was a trend towards physicians being more likely to provide poor quality care if they had fewer patients with schizophrenia in their practice ($r = 0.60$, $p = 0.06$). Risk for poor care was greater in patients with more prior hospitalizations (odds ratio [OR] = 1.05 per hospitalization, $p = 0.05$), older age (OR = 1.6 per decade, $p = 0.04$), and poor compliance (OR = 2.8, $p = 0.02$). There were trends towards poor management of symptoms in men and substance abusers, and poor management of side-effects in black patients. Provision of poor quality care was associated with failure to document symptoms and side-effects in the medical record.

Researchers concluded that interventions targeting patients and providers are needed to improve the quality of medication management in schizophrenia. Interventions should address the challenging clinical situations often seen in schizophrenia, emphasizing improved evaluation of symptoms and side-effects and incorporating organizational changes and elements to improve patient compliance, such as family and patient education.*



MINORITY VETERANS' PERCEPTIONS OF VA HEALTHCARE: A VIEW TOWARD IMPROVEMENT

The Veteran Identity Program (VIP) was developed by VA West Los Angeles Healthcare Center researchers to 1) understand how factors related to ethnicity and veteran identity influence utilization of VHA ambulatory care and other healthcare services, and 2) use these findings to design program and practitioner interventions to improve access of minority veterans to ambulatory care. Led by Center researchers Nancy Harada, PhD and Joanne Damron-Rodriguez, PhD, MSW, and joined by Center affiliated researcher Donna Washington, MD, the VIP is a large, 4-year effort funded by VA HSR&D Service.

To achieve project goals, the researchers conducted 16 focus groups of users and non-users of the VA healthcare system (n = 178). The design included sampling by two major war cohorts (WWII and Vietnam) and by

race/ethnicity (African-American, Asian, Caucasian and Hispanic). Focus groups were held at eight different community sites and facilitated by trained non-VA facilitators of the same racial/ethnic background as participants. Reasons that veterans use or do not use the VA, as well as suggestions for improvement, were assessed. Content analysis of transcriptions was performed using NUDIST, a qualitative software program. Facilitators and barriers to VA use were ranked and illustrative quotes were identified. Veterans' perception of their military experience was compared to their perception of VA healthcare.

The researchers found racial/ethnic and war cohort differences for both perceptions of VA healthcare and suggestions for improvement. Groups with higher positive

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Guideline Recommendations *(Cont. from page 3)*
Licht, MD, worked with Brian Mittman, PhD (VA Sepulveda) and Barbara Vickrey, MD, MPH, (UCLA) to examine conflicting recommendations and other variations in guidelines for a single chronic illness in patients often treated by physicians in multiple specialties—women with epilepsy of childbearing age—for whom consistency of recommendations and coordination of care can be critical.

The researchers identified 16 relevant guidelines through Medline searches and by contacting medical specialty organizations and private agencies involved with issues of reproductive health. Guidelines were rated and classified on several dimensions related to guideline content and format (e.g., breadth of clinical issues, patient populations addressed, specific recommendations included), and guideline development (composition of development committee, type of external review, methods used in evidence gathering and analysis). They examined guideline conflicts and inconsistencies and tested hypotheses regarding the influence of guideline development and agency characteristics on guideline content and format.

Marked differences in guideline coverage and specific recommendations were

noted, including areas of direct conflict. For example, inconsistencies were found in recommended dosages of folate to reduce risk of neural tube defects, ranging from 0.4-5 mg/day of folic acid; one agency failed to recommend any specific dose. Guidelines from neurology-based organizations addressed issues often excluded from guidelines developed by non-neurology groups (e.g., risk of neonatal hemorrhage from anti-convulsants), while guidelines created by public agencies (governmental and not-for-profit, public service agencies) differed significantly from those developed by private specialty societies and other organizations.

Inconsistencies and conflicts in clinical practice guidelines may undermine physician confidence and acceptance. Furthermore, differences in physician knowledge and clinical emphasis—and fragmented, inconsistent care, are more likely to result when different specialties rely on separate and conflicting practice guidelines. Greater cooperation between organizations developing guidelines is needed, particularly when large, shared patient populations are involved, to produce recommendations more likely to be accepted by physicians and more likely to unify rather than fragment clinical practices.✱

CONCEPTUALIZING SPIRITUAL WELL-BEING: A FOCUS GROUP STUDY OF OLDER ADULTS WITH CHRONIC ILLNESS

Improving the health-related quality of life (HRQOL) of individuals with chronic illness has become a major goal of contemporary health care, creating the need for measurement tools that accurately assess individuals' HRQOL. Current HRQOL assessment tools have focused nearly exclusively on its physical, emotional, and social components, despite research evidence that spiritual well-being is important in the context of chronic or terminal illness. As the first phase of a project to develop a spiritual well-being instrument, VA HSR&D Career Development Awardee Kenneth Rosenfeld, MD (VA West Los Angeles Healthcare Center) sought to construct a conceptual model for spiritual well-being, from the perspective of older adults with chronic illness. Funding for this work was provided by the AARP Andrus Foundation.

Dr. Rosenfeld conducted eight focus groups of older individuals with chronic illness. A diversity of perspectives was sought through stratification by one or more of the following variables: age (65-74, >74); race (Caucasian, African-American, Spanish-speaking Latino); and chronic illness category (heart disease, lung disease, arthritis, visual impairment). Participants were asked about the meaning of spiritual health; the characteristics of spiritually healthy people; what they did to maintain spiritual health; and how aging and chronic illness influenced spiritual health. Focus groups were audiotaped and transcribed verbatim (and translated for Spanish-speaking groups), then coded for thematic structure by two independent coders trained in content analysis. "Trustworthiness" (the qualitative equivalent of validity and reliability) of the analysis was sought through checks on inter-rater reliability, respondent feedback to the findings, and concurrence by a panel of spirituality experts.

Focus group participants expressed a wide range of perspectives on spiritual health. Many participants equated spirituality with formalized religious commitment, although a variety of non-religious elements were also identified. Analysis of the focus group transcripts yielded themes in five major areas, with substantial overlap between them: 1) spiritual orientation (e.g., religious or spiritual practices, connection to God); 2) existential state (e.g., meaning and purpose in life, attitude towards death); 3) interper-

sonal relationships (e.g., loving and being loved, helping others); 4) outlook (e.g., "glass half full") and 5) affect (e.g., inner peace, joy).

Dr. Rosenfeld concluded that spiritual health was an important dimension of older, chronically ill individuals' HRQOL. Contrary to historical attempts to define spirituality in terms of its religious elements, our analysis suggested that a definition that includes its psycho/developmental elements may better represent patients' own models of spiritual health. Several theme areas identified in this study (e.g., affect, interpersonal relationships) correspond to previously identified HRQOL dimensions (emotional well-being, social well-being), although other identified areas (spiritual orientation, existential, positive outlook) are not currently represented in HRQOL assessment tools. Expanding the conceptualization of HRQOL to include spiritual well-being may be appropriate in studies in aging and chronic illness. Furthermore, if spiritual well-being represents a unique dimension of HRQOL, then current instruments may not fully capture the impact of chronic illness and its treatment on patients' HRQOL. The conceptual model developed in this study will be used to create an instrument that measures spiritual well-being, and tests its unique contribution to HRQOL.✱



VA QUALITY ENHANCEMENT RESEARCH INITIATIVE (QUERI) FOR HIV/AIDS

The VA HIV/AIDS QUERI effort, based at the Center's San Diego VA site, was established last year to apply research to the improvement of healthcare quality and outcomes for HIV/AIDS patients in the VA. The HIV/AIDS QUERI group, under the direction of Samuel Bozzette, MD, PhD, is one of 8 such research groups established throughout the VA QUERI program. The HIV/AIDS QUERI team has made significant progress in its initial year, with approval and funding of a Service-Directed Research project and approval of two Investigator-Initiated Research grants. The recent establishment of the QUERI's Clinical Coordinating Center at the new Center for Quality Management for HIV at the Palo Alto VA, led by Sophia Chang, MD, will also contribute substantially to achievement of the QUERI team's goals.

Plans for the coming year include increased emphasis on gaps in knowledge regarding comorbidities and their consequences, both unrelated and related to HIV. In particular, the Research Coordinating Center component of the QUERI (located at the San Diego VA) intends to pursue pilot projects relating to patients dually diagnosed with substance abuse or other mental disorders or suffering from or at risk for selected medical comorbidities (hepatitis C, treatment-related lipid disorders and their sequelae such as coronary artery disease), and other diseases of aging as the HIV-infected veteran population grows older. Based on recently-completed pilot work, the QUERI-HIV anticipates proposing Service Directed Research on the prevalence, management, and outcomes of these conditions. The QUERI-HIV continues to monitor gaps in knowledge regarding the significance of phenotypic and genotypic drug resistance.

The QUERI will also focus on veterans not receiving care—a critical area identified by the VA AIDS Service and others in the HIV treating community. Gaps in knowledge clearly exist in both the general and veteran population along several dimensions, but are being continuously filled. For example, recent studies have showed that only half of African-Americans reject AIDS-conspiracy views and that fears of victimization after diagnosis are not unfounded. The QUERI-HIV will be monitoring and assisting in activities to identify knowledge gaps conducted by the Director of Prevention for the

AIDS Service. The QUERI Research Director, Sam Bozzette, is also participating in the CDC's National Prevention Planning Group and will monitor that group's activities for information and gaps relevant to the veteran population.

The QUERI is making significant progress in identifying and promoting best practices in other ways. For example there is increasing concern that many established treatment recommendations are too aggressive. The QUERI-HIV will be active in the debate regarding the appropriateness of early aggressive combination antiretroviral therapy. Through its collaborations with the AIDS Service and the HCSUS, the QUERI-HIV will be in a position to help inform these discussions as many of the concerns relate to chronic toxicities and the ability to maintain long term suppression of viremia. In addition, QUERI-HIV personnel will assist as appropriate in a proposed VA clinical trial on when to switch or start therapy.

The QUERI is also pursuing research and quality improvement activities related to the well-established finding that experienced HIV providers and clinics with more HIV-specific services yield better patient outcomes. As treatment becomes more complicated and difficult, understanding the nature of individual and institutional competence becomes more important. QUERI-HIV staff are assisting consultants Paul Cleary and Bruce Landon in analyzing the role of experience and training, and clinical organization on process and outcome quality in a national probability sample of persons with HIV. QUERI-HIV staff participated in a project examining how case management is effective in reducing unmet medical needs. The QUERI staff anticipate that proposals for interventions will arise from this and similar work.

Finally, the QUERI-HIV is participating in this first national conference of HIV providers, which is being organized by the QUERI Clinical Coordinating Center. This conference, which will include the principle HIV clinician or their designee plus one other person (generally the AIDS coordinator), will be a venue for both information dissemination and gathering.*

VA HSR&D CENTER STRATEGIC PLAN

STRATEGIC PLAN

The Center recently completed a strategic planning process, as part of a VHA Headquarters-mandated review. This process provided an opportunity to evaluate the Center's progress in achieving its goals during its first five years of existence, and to assess its mission and directions for the next five years and beyond. The strategic planning process involved Center leadership, investigators and Advisory Board members and yielded a renewed vision, mission and goals for fiscal years 2000 through 2004.

Vision

Consistent with VHA HSR&D goals, the Center for the Study of Healthcare Provider Behavior endeavors to improve the quality of VA healthcare by providing broad-based expertise in the theoretical basis, design, implementation, and evaluation of interventions to change healthcare provider behavior and the healthcare systems that influence provider behavior. The Center's knowledge base will be continually renewed through new research and literature reviews, and continually disseminated through publications, conferences and sponsorship of health services research training programs.

Mission

The Center's mission is to promote better healthcare for veterans through better understanding of healthcare provider behavior, the factors that influence it, and the health systems interventions that will improve it.

Overview

The Center for the Study of Healthcare Provider Behavior is a Department of Veterans Affairs Health Services Research and Development (HSR&D) Service Center of Excellence. The Center is comprised of health services researchers who conduct research, education and dissemination in the area of healthcare provider behavior within an infrastructure designed to support their activities. Researchers are affiliated with a consortium of institutions supporting Center activities. Consortium member institutions include the Sepulveda and West Los Angeles campuses of the VA Greater Los Angeles Healthcare System, the VA San Diego Healthcare System, the University of California campuses at Los Angeles (UCLA) and San Diego

(UCSD), and the RAND Health Program in Santa Monica. RAND is a not-for-profit organization with longstanding connections to the Department of Defense and VHA and a strong commitment to health services research. The Center is directed by Lisa V. Rubenstein, MD, MSPH, a nationally recognized health services researcher and leader in general internal medicine. Core Center leadership is provided by the Associate Director (Yano), the Senior Social Scientist (Mittman) and an Executive Committee (Rubenstein, Shekelle, Bozzette).

Center Strategic Goals

The Center has seven strategic goals for FY2000 through 2004.

1. To identify theoretical and empirical models of healthcare provider behavior and quality of care.
2. To develop, refine, and evaluate health systems interventions based on these models to improve the quality and outcomes of care.
3. To identify and propose solutions for methodologic problems confronting health systems interventions, including those based on statistical, epidemiologic, and data collection techniques.
4. To train VA health services research fellows, career development awardees, and their peers about development, implementation, and evaluation of health systems interventions.
5. To disseminate resource and intervention materials, research results and recommendations to the VA health system and the American public.
6. To support the development and implementation of the VA Quality Enhancement Research Initiative (QUERI).
7. To continue to build appropriate infrastructure to support research, education and dissemination goals.*



STAFF NEWS

Center staff have initiated or made significant progress on several research projects during the past six months, and have disseminated results of this work in a number of written and oral presentations.

Scott Sherman, MD, has received funding from Pfizer Health Solutions to conduct a randomized, controlled trial examining whether a system for follow-up and case management improves health outcomes in veterans who were previously diagnosed with depression or depressive symptoms. Patients are chosen for participation in this study by reviewing Primary Care Encounter Forms and Primary Care Psychiatry logs. Patients are contacted by phone by **Debbie Mittman**, Project Manager, who administers a brief interview (SF-12V). Patients who are still depressed are given a referral appointment to their primary care provider who will then determine whether referral to psychiatry is necessary. This allows for the identification and follow-up of patients who haven't fallen out of treatment or relapsed. This study is due to conclude in December 2000.

Dr. Sherman's VA HSR&D-funded smoking cessation guideline implementation project, Quality Improvement Trial for Smoking Cessation (QUITs), completed a survey of participating VA facilities during early 2000, and will begin patient recruitment and screening in March. This project will use the Center's newly-developed, state-of-the-art telephone survey facility, complete with individual phoning stations, each of which is equipped with direct-dial telephones with headsets, computer terminals, and filing space for work in progress. The VA HSR&D Center of Excellence has conducted paper-and-pencil telephone surveys until

this year.

The VA Telephone Call Center uses an on-line, computer-assisted telephone interviewing (CATI) software system developed by CfMC (Computers for Marketing Corporation), a private corporation in San Francisco. The CATI technology makes the interviewer's task simpler and more efficient. With CATI, interviewers read questions from video display terminals and enter responses directly into the computer. CATI is programmed to skip interviewers through the proper sequence of questions and allows for quick, efficient data entry. With the aid of CATI, telephone interviews can be conducted quickly, thereby reducing the time a respondent must devote to the interview.

Elizabeth Yano's VA HSR&D-funded VHA Survey of Primary Care Practices was conducted during the summer of 1999, with a 93% response rate. Survey results will be disseminated to all VISN directors and facility leaders, and to research audiences through conference presentations and manuscripts. The 1999 survey expanded on earlier national surveys of VHA primary care practices, conducted by the Center in 1993 and 1996.



HSR&D Call Center

Lisa Rubenstein presented the keynote plenary lecture at the NIMH-sponsored "13th International Conference on Mental Health Problems in the General Health Care Sector: Improving Public Mental Health Through Quality Interventions in Primary Care." Her lecture, entitled "Innovative Approaches to Improving Primary Care," synthesized several years of research findings regarding strategies for improving primary care delivery, including the results of Center research. Dr. Rubenstein was recently appointed to the faculty of the Institute for Healthcare Improvement, where she will lead seminars and facilitate projects on quality improvement strategies in primary care and other healthcare delivery settings.

Brian Mittman and **Andrew Wong**, an investigator at Olive View-UCLA Medical

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STAFF NEWS CONTINUED

Center, received funding for a new outcomes research program within the Los Angeles County Department of Health Services. The initial project in this program, evaluating new treatments for rheumatoid arthritis, will begin enrolling patients during March 2000. Funding. Center staff members **Alissa Simon** and **Chris Donald** are serving as the Project Manager and Research Assistant, respectively.

James Lohr, Center investigator at the VA San Diego Healthcare System, recently received a new VA HSR&D Investigator Initiated Research grant under the Patient-Centered Care program to compare community-based and VA hospital-based treatment for serious mental illness. Using a randomized controlled trial design, this study will measure process and outcomes of care--including patient-centeredness of the care systems--among patients presenting to the San Diego VA psychiatric facility. Approximately one-half of these patients will be assigned to VA treatment and one-half to community-based residential programs.

Alexander Young, a Center investigator located at the WLA campus and Associate Director of the VISN 22 Mental Illness Research, Education and Clinical Center (MIRECC), has received funding for a new project to improve rehabilitation and empowerment competencies in providers caring for the seriously mentally ill under managed Medicaid. His other research activities include analyses of data from recently-completed quality of care projects in schizophrenia and depression, to further develop effective quality measurement methods. His findings will be applied to planned quality improvement projects targeting schizophrenia within the VA.

John Peabody, MD, PhD, a Center investigator and VA HSR&D Career Development Awardee formerly based at the Center's West LA VA site, has accepted a position as Staff Physician at the San Francisco VAMC, with a faculty position at the UC San Francisco Departments of Epidemiology and Biostatistics and Medicine. He has two papers in press (at the *American Journal of Medicine* and *JAMA*) reporting results of his VA HSR&D-supported research on quality measurement methods. The first paper is entitled "How Well Does Chart Abstraction Measure Quality? A Prospective Comparison of Quality Between Standardized Patients and the Medical Record" and assesses the rate of false negative and false positive findings in using medical records to assess the quality of VA

outpatient care. The second paper, entitled "Vignettes, Standardized Patients and the Medical Record: A Prospective Validation Study Comparing Three Methods for Measuring Quality," demonstrates the feasibility and validity of a clinical vignette-based method for measuring and comparing quality across care settings.*

Minority Veteran's Perceptions (*Cont. from page 5*) evaluations of the military had higher assessments of VA healthcare. Caucasians and Asians of all war cohorts, and African-American Vietnam veterans were the most critical of the VA system. The top five barriers or reasons to not use the VA included: employees (including physicians), poor information regarding services, waiting time for and at appointments, denied access, and inconvenience. Illustrative statements include: "The way we became Americans is being WWII veterans. So there's no reason why we've not been given ID cards. I hope you leave that on (the) record." (Asian WWII veteran); "The guys who did what it took to become disabled deserve the benefit. They're being told by people who have no idea what went on, 'so what, and we don't care.'" (Caucasian Vietnam veteran); "I go to a private doctor. They're more accountable for what they do. At the VA you see doctors that are given to you...it wasn't my health that they were concerned about." (African-American WWII veteran). A common theme in both positive and negative statements was the expectation that VHA should provide services that are veteran related, and in a manner that particularly acknowledges their veteran experience and how it varies by background.

The researchers concluded that veterans' military and racial/ethnic experiences frame their perception of the VA healthcare system, and how they feel about VA health care services. These findings will be used to frame questions for a survey of 3,200 veterans in VISN 22, in order to formulate interventions from the veteran's perspective for improved access. Customer service training that aims to increase provider and staff sensitivity to minority veteran's unique sense of identity deserves examination as a strategy to increase access and satisfaction.*



FELLOWS NEWS

Gareth Dulai, MD, is a new Ambulatory Care Fellow based at the West Los Angeles site. Dr. Dulai is a gastroenterologist with research interests in risk stratification in VA patients with Barrett's esophagus. He is developing methods for identifying cases of Barrett's esophagus in VISN22, and using VHA facility pathology databases and medical record reviews to stratify patients according to baseline presence and grade of dysplasia. He then plans to use medical records, tumor registries and death certificate data to identify relevant outcome endpoints in anticipation of promoting the establishment of a regional VA registry of Barrett's esophagus.

Claudia Landis, MD, recently completed a VA Women's Health Fellowship at the West Los Angeles site. Dr. Landis compared self-care hemodialysis and conventional full-care hemodialysis in her fellowship project, resulting in several conference presentations and a paper that has been accepted for publication. Following the conclusion of her fellowship, she was recruited by a large, multi-site company that owns a large percentage of the nation's dialysis units and is involved in academic work related to clinical nephrology.

Claudine Armand, MD, is a new Women's Health fellow at the Sepulveda site. Dr. Armand received her MD at the Albert Einstein College of Medicine in 1996 and completed her residency in the UCLA-San Fernando Valley Program in General Internal Medicine. She is interested in clinical, health services and policy issues in women's health. Her current interests include women's sexuality and the impact of sexual dysfunction on employment, relationships and psychological outcomes.

Cynthia Caffrey, MD, is a new Women's Health fellow at the Sepulveda site. Dr. Caffrey received her MD from the Medical College of Pennsylvania in 1995, followed by a residency at the UCLA-San Fernando Valley Program in General Internal Medicine, where she served as Chief Resident at Sepulveda. She is interested in assessing determinants of variations in rates of cervical cancer screening and mammography in VHA facilities, further comparing these rates to community standards and Healthy People 2000 goals.

Jill Bormann, PhD, MSN, RN, was awarded a one-year VA nurse postdoctoral fellowship. Dr. Bormann earned her PhD in Nursing at Wayne State University and her MSN in Psychiatric Nursing at the University of Texas, Austin. Dr. Bormann's research interests include treatment adherence among veterans with HIV/AIDS. As an existing member of the HSR&D Center of Excellence affiliate in San Diego, the fellowship will afford her protected time to pursue her research, increasing her readiness as an independent nurse investigator in anticipation of future VA HSR&D Nursing Research Initiative proposals.

Marisa Smith is a former Center VA HSR&D pre-doctoral fellow at the Department of Sociology of the University of California, San Diego (UCSD). Ms. Smith's research interests address variations in veterans' mental health diagnoses by gender and period of service, with specific emphasis on post-traumatic stress disorder. She has presented findings from her research at recent meetings of American Sociological Association. Her dissertation chair is Andrew Scull, PhD, also Chair of the UCSD Department of Sociology; her VA mentor is Samuel Bozette, MD, PhD.

Leah Vriesman, MBA, MHA, is a doctoral student at the UCLA School of Public Health, Department of Health Services and a VA HSR&D Predoctoral Fellow based at the Sepulveda VA. Ms. Vriesman is conducting her dissertation research on the impact of VHA facility integrations on costs and market factors. Her dissertation chair is Ron Andersen, PhD, and her VA mentors are Center Core faculty Brian Mittman, PhD, and Elizabeth Yano, PhD.

Alvin Mares, MSW, is a doctoral student at the UCLA School of Public Policy and Social Research and a VA Social Work and HSR&D Predoctoral Fellow based at the VA West Los Angeles Healthcare Center. Mr. Mares is conducting an outcomes evaluation of VA board-and-care facilities. His UCLA dissertation chair is Stuart Kirk, PhD, while he has had the benefit of VA mentoring from Jim McGuire, PhD (Community Care), and Paul Shekelle, MD, PhD (Center Site Director). He presented results from his initial research at the 1999 HSR&D Service Annual Meeting.✱

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DEADLINES



Investigator Initiated Research (IIR)

- ◆ Letters of Intent Anytime
- ◆ Applications (for approved LOIs) May 1 & Nov 1

Career Development Awards (CDA)

- ◆ Letters of Intent May 1 & Nov 1
- ◆ Applications (for approved LOIs) Aug 15 & Feb 15

For more information on center activities, including any of the studies described in this newsletter, please contact us by email:

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