

provided. Using the internal reporting template, the number of process-related measures will be presented. For outcome-related measures, the global metric reporting approach will be described and a reporting template will be shared. An example of a project-specific reporting template will be presented.

Lessons Learned: To date, we have learnt that the key steps to establishing a new CDP include early involvement of key clinical expert stakeholders in guideline development, the need to minimize the burden of these clinical experts, and involvement of senior leadership as needed to ensure that progress continues to be made. In addition, collaboration is important to minimize duplication of effort and to increase the efficiency of the CDP. Finally, developing a plan a priori for guideline dissemination, implementation, and assessment is needed.

CASE 6

THE USE OF AN EVIDENCE-BASED PRACTICE STRATEGY TO IMPROVE QUALITY IN THE ACUTE CARE SETTING

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Organization: Mercy Health Partners, Southwest Ohio. The regional office consists of 5 acute care hospitals and 6 Long Term Care Nursing Homes with over 8000 employees and 2000 physicians on staff.

Problem or Issue Addressed: The availability of a growing body of high quality evidence-based practice guidelines has created exceptional opportunities to maximize the quality of care delivered to patients. However, are we utilizing the available evidence in daily practice, or are individual clinician preferences still dictating practice levels? Can evidence-based practice recommendations be translated into a community-based health care system? **Goals:** The provision of evidence-based practice attributes within a series of designated order sets; The ability to maximize consistency, reduce variability, and to evaluate the delivery of quality patient care; The ability to build-in practitioner flexibility for those respective areas, not supported by evidence-based practice; To utilize an available "evidence-based practice" database, which is continuously updated, and which allows timely dissemination of updates across numerous disease entities.

Outcomes items used in the decision: We utilized effectiveness data as reported in the peer-reviewed literature along with currently available evidence-based classification schemes. Additionally, we utilized the commercially available database, Zynx. Rates of order set implementation were captured through a program which allowed us to evaluate the clinical and financial outcomes associated with the newly adopted order sets versus alternative order sets used by clinicians.

Implementation Strategy: The initial step in our implementation process occurred when our Healthcare Systems' Board of Trustees and Physicians Council agreed upon a goal to advance a culture of quality through evidence based medicine and clinical transformation during the early spring in 2006. After a series of meetings held for the systems' key clinical decision makers, an initial group of order sets were identified for review, based on high use, high costs, and key components of our Core Performance Practice Measures. A group of 10 clinical order sets, which included Community Acquired Pneumonia, Heart Failure, Chest Pain, Caesarean Section Delivery, Pelvic Delivery, Special Care Nursery, Newborn Nursery, Deep Vein Thrombosis Prophylaxis, and Erythrocyte Stimulating Factors. Through the consensus process, the clinical leadership adopted an evidence-based algorithm for our health system, which was subsequently approved by our Board of Trustees. The algorithm employs select

evidence classification schemes currently available in the peer-reviewed literature. The order sets were all adopted by the health system. A final step in the process was to develop an electronic data capture instrument, which would allow us to quantify the implementation rate for each of the order sets that were approved.

Results: We will share the financial and clinical outcomes, which have been evaluated for our initial order sets as well as select metrics, which demonstrate the level of acceptance within our Health System.

Lessons Learned: The initial lesson learned early in our implementation process was that trying to standardize clinical practice amongst a large group of physicians throughout a five-hospital health care system will occur via an evolutionary process rather than a revolutionary process. Additionally, we learned that the development of order sets required two key components, 1) An evidence-based component based on a high degree of literature-based recommendations, and 2) A practice-based component, which utilized clinician-practice experience, not in conflict with evidence-based practice, for those areas not supported by evidence-based recommendations.

CANCER OUTCOMES RESEARCH

CNI

TRENDS IN TREATMENT AMONG ELDERLY COLORECTAL CANCER PATIENTS IN THE US: EVIDENCE FROM LINKED SEER-MEDICARE DATA

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OBJECTIVE: This study used linked SEER-Medicare data to analyze recent treatment patterns and trends among elderly CRC patients in the US. **METHODS:** Study cohorts included patients aged 65+ newly diagnosed with adenocarcinoma of the colon (CC) or rectum (RC) between 1996 and 2002 (n = 60,916) and 1:1 age/sex/location-matched patients from a Medicare 5% sample. Cohorts were followed from index until death or December 31, 2005 to evaluate differences in clinical characteristics, resource use, and initial treatment modalities by cancer site and stage. To analyze trends, a standardized 3-year follow-up was used. **RESULTS:** Mean (\pm SD) age among CRC patients and controls was 77 (\pm 7) years, 46% were male, and 84% were white. About 28% of patients had rectal cancer. Overall, 7% of CRC patients were diagnosed at Stage 0, 24% at Stage 1, 28% at Stage 2, 21% at Stage 3, and 15% at Stage 4 (remainder were unstaged). Between 1996 and 2002, surgery was the primary treatment among CC patients (range: 73–78%), followed by combined surgery/chemotherapy (16–20%), with very little radiation use (<2%). Among RC patients, surgery was the primary treatment (range: 53–56%), followed by surgery/chemoradiotherapy (15–17%), surgery/radiotherapy (8–11%), surgery/chemotherapy (7–9%) and no treatment (7–11%). CRC patients used significantly ($P < .001$) more health care resources than controls in every category, with the largest differences in use of hospital (23 vs. 12 days), home health (47% vs. 30%) and hospice (24% vs. 9%). Use of all resources remained steady from 1996 to 2002, with slight declines in use of home health (from 47% to 41%; $P < .001$) and skilled nursing (from a mean of 9 to 8 days; $P = .017$) and a slight increase in hospice use (from 16% to 19%; $P < .001$). **CONCLUSION:** Treatment patterns and resource use among CRC patients remained steady between 1996 and 2002, and resource use was substantial.