

## At A Glance

July/August 2006

### Monthly highlights of ICES research findings for stakeholders

#### Significant proportion of Ontario cancer patients have poor quality end-of-life care

Barbera L, Paszat L, Chartier C. Indicators of poor quality end-of-life cancer care in Ontario. *J Palliat Care*. 2006; 22 (1): 12-17.

<b>Issue</b>	There is increasing recognition that proper palliative and end-of-life (EOL) care is an important part of the continuum of cancer care and that it is possible to evaluate the quality of EOL care.
<b>Study</b>	Identified Ontario cancer patients who died in 2001 and measured the proportion of these patients with intensive care unit (ICU) admissions, emergency room (ER) visits or chemotherapy in the last two weeks of life, indicators which may signal poor quality EOL care in late-stage cancer patients.
<b>Key Findings</b>	In the study group, 27% had at least one ER visit and five per cent had an ICU visit in the last two weeks of life. Of those who received chemotherapy in the last six months, 16% received chemotherapy in the last two weeks of life. A home care visit in the last six months of life, or a physician house call or a palliative care assessment in the last two weeks of life was consistently associated with decreased odds of each of the indicators noted above.
<b>Implications</b>	The use of non-physician home care, physician house calls and palliative care assessments may help decrease the frequency of ER visits, ICU admissions and chemotherapy at the end of life.

#### Clinical trials that use acronyms are cited more often

Stanbrook M, Austin P, Redelmeier D. Acronym-named Randomized Trials in medicine: the ART in medicine study. *N Engl J Med*. 2006; 355 (1): 101-102.

<b>Issue</b>	The use of acronyms to name clinical trials is increasingly popular yet controversial. However, it is unclear whether the use of acronyms to name clinical trials has any effect on the uptake of research findings.
<b>Study</b>	Classified randomized trials published between 1953 and 2003 in terms of whether or not they had a name composed of an acronym in order to assess whether the use of acronyms impacts the uptake of research findings. Uptake was measured by the citation rate after publication of the study.
<b>Key Findings</b>	Of the 173 studies identified, 59 (34%) were named with an acronym. Acronym-named randomized trials were cited at twice the rate of trials that were not named with acronyms (13.8% vs. 5.7% per year).
<b>Implications</b>	Although enhanced attention to and recall of studies with acronyms may facilitate the appropriate translation of research findings into clinical practice, these studies may also undermine evidence-based practice if they exert influence beyond the clinical credibility of the project.

#### Study identifies performance measures for emergency department care for children

Guttman A, Razzaq A, Lindsay P, Zagorski B, Anderson G. Development of measures of the quality of emergency department care for children using a structured panel process. *Pediatrics*. 2006; 118 (1): 114-123.

<b>Issue</b>	Emergency department (ED) care is an integral component of the care provided by hospitals, yet limited work has been undertaken to develop performance measures for the care of children in EDs.
<b>Study</b>	Assembled an expert advisory panel of health care providers and managers to review ED utilization data for children 0-19 years of age, between April 2003 and March 2004, to identify a series of common conditions seen in EDs that could be targeted for quality improvement efforts.
<b>Key Findings</b>	The panel defined 68 specific clinical indicators that could be used to measure ED performance for 12 conditions. These conditions covered a range of acuity levels and accounted for about 23% of all pediatric ED visits. Using routinely collected data sets, it was possible to calculate 19 of these indicators, covering nine clinical conditions, representing 20% of all ED visits by children.
<b>Implications</b>	This research can provide health care practitioners, managers and researchers with tools to measure performance and guide quality improvement efforts with the ultimate goal of improving ED care for children.

## ICES report presents in-depth look at primary care across the life-cycle

Jaakkimainen L, Upshur R, Schultz S, Maaten S, editors. Primary Care in Ontario: ICES Atlas 1<sup>st</sup> Installment. Toronto: Institute for Clinical Evaluative Sciences; 2006.

<b>Issue</b>	The delivery of primary care services in Ontario has been in transition over the past decade. A comprehensive, descriptive analysis of primary care utilization patterns is needed to provide baseline information against which to evaluate reform initiatives.
<b>Study</b>	Examines current trends in primary care for women during pregnancy, labour and childbirth; the care of children; the care provided to adults; and patterns in preventive health care between 1992/93 and 2002/03, prior to the introduction of new primary care reform initiatives in Ontario, such as Family Health Teams.
<b>Key Findings</b>	Obstetricians and midwives are providing more primary care services to pregnant women, and the number of older mothers and multiple and caesarean births are increasing. Among children, the average number of primary care visits is decreasing; the proportion with no primary care visits is increasing; and, there is a three-fold variation in visit rates across the province. Pediatricians are providing an increasing amount of primary care to children. The number of adults with no physician visits is increasing in younger adults, and decreasing in older adults. The proportion of older adults seeing both general practitioners/family physicians (GP/FPs) and specialists increases with age. Indicators of primary prevention, such as Body Mass Index (BMI), physical activity, vaccination rates, and decreases in tobacco use, are suboptimal. However, a large percentage of adult women report having received preventive primary care, such as a pap smear, a clinical breast exam and/or a mammogram.
<b>Implications</b>	New models and initiatives for primary care reform in Ontario need to consider and address the trends shown in this report to ensure that they are successful in bringing the best care in the most appropriate manner to Ontarians.

## Landmark report examines influence of geography on heart disease patients across Canada

Tu J, Ghali W, Pilote L, Brien S, editors. Canadian Cardiovascular Outcomes Research Team (CCORT) Canadian Cardiovascular Atlas. Toronto: Institute for Clinical Evaluative Sciences; 2006.

<b>Issue</b>	In light of the large burden of cardiovascular disease on the Canadian health care system, it is necessary to develop a better understanding of how cardiac health services are delivered in Canada and where improvements are needed in the system.
<b>Study</b>	Examined the influence of geography on the burden, risk factors, treatments, and outcomes of heart disease for the more than 1.2 million Canadians suffering from the condition in a collective series of 24 articles originally published in the <i>Canadian Journal of Cardiology</i> .
<b>Key Findings</b>	Cardiovascular disease continues to be the leading cause of death in Canada, responsible for 37% of all deaths in the country. Much of the variation in cardiovascular death rates across Canada can be explained by regional variations in traditional cardiovascular risk factors, such as smoking and obesity levels in communities. There is suboptimal treatment of heart attack patients across the country in certain areas of acute hospital care, and also variations in the proportion of people who are treated by a cardiologist. There is significant variation in the rates of cardiac procedures and cardiac drug spending across Canada that do not appear to reflect differences in clinical need, but rather other factors such as variations in policy, physician practice styles, and possibly patient preferences.
<b>Implications</b>	All Canadians do not have similar levels of access to quality cardiac care, and where a person lives can determine the type of treatment received. There is a need for a coordinated pan-Canadian approach to measuring and improving the quality of cardiac care. The results of this work can serve as an important aid for policy makers and clinicians working towards achieving this objective.

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