IRENE
Iowa Research Network
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IRENE MISSION and PURPOSE

IRENE's mission is to improve the health and well-being of Iowans through collaboration in practice-based research on questions important to primary care physicians and their patients. IRENE's purpose is to create and foster a network of research collaboration between the academic medical center and primary care physicians through out the state of Iowa with a particular focus on improving rural health.

IRENE Web Site
http://www.uihealthcare.com/depts/med/familymedicine/research/irene/index.html

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UI Awarded $33.8 Million for Clinical and Translational Research

The National Institutes of Health (NIH) recently announced that the University of Iowa is one of 12 academic health centers nationwide to receive a Clinical and Translational Science Award (CTSA) for a five-year, $33.8 million award. The CTSA will support the University's Institute for Clinical and Translational Science to expand and enhance "bench-to-bedside" research -- laboratory discoveries that lead to patient-based studies in clinical settings. Dr. Levy is a co-investigator on the award with IRENE.

103 Screened at Tyson Plant for Diabetes

In May 2007, three research assistants for the Department of Family Medicine conducted blood glucose screening at the Tyson Food Plant in Waterloo, Iowa. One hundred and three workers were screened with six having elevated blood glucose, one of which was 396. In addition to the blood glucose screen, for those with elevated blood glucose, we offered the HbA1c test. Two A1c's were above 7% at 9% and 12% respectively. These individuals were counseled and referred to their physicians. Bosnian and Hispanic translators were present in order to facilitate communication with non-English speaking plant workers.

IRENE WISE QI Project Update

The project entitled, "An Evaluation of the WISE QI Program," funded by the Agency for Healthcare Research and Quality has begun recruiting potential participants. The purpose of the project is to test the effectiveness of a multifaceted intervention program to improve the quality of care for high-risk diabetic patients in rural settings. The program to be tested is the Wellmark Incentive-Support to Encourage Quality Improvement (WISE QI) which is based on the chronic care model. The following 4 practices and their nurse coordinators are participating:

Manchester Family Medical Associate
Manchester, Iowa
Rebecca Bahls, RN

McFarland Clinic
Carroll, Iowa
Jodi Miller, RN

Medical Associates, PC
Le Mars, Iowa
Kari VanDam, RN

North Liberty Clinic
North Liberty, Iowa
Diane Vileta, RN

Recent IRENE Publications

Colorectal cancer testing among patients cared for by Iowa family physicians.

Levy BT, Dawson J, Hartz AJ, James PA. (2006). American Journal of Preventive Medicine, 31(3), 193-201.

BACKGROUND: Colorectal cancer (CRC) can be largely prevented or effectively treated, yet about half of eligible Americans have not been screened. The purpose of this study was to examine patient and physician factors associated with documented CRC testing according to national guidelines.

METHODS: Cross-sectional study where 511 randomly selected rural patients aged 55 to 80 years of 16 board-certified Iowa family physicians were enrolled in 2004. Patient survey and medical record information were linked with physician surveys. Predictors of CRC testing were examined using a regression procedure that accommodated random physician effects (2005-2006).

RESULTS: Forty-six percent of patients were up-to-date with CRC testing in accordance with national guidelines. This percentage varied from 5% to 75% by physician ($p < 0.0001$). Of the patients who were up-to-date, 89% had colonoscopy, and 62% had symptoms prior to testing that could indicate CRC. The strongest univariate predictors other than symptoms were patient recollection of physician recommendation (odds ratio [OR] = 6.4, 95% confidence interval [CI] = 4.2-9.6) and physician documentation of recommendation (OR = 14.1, CI = 8.5-23.3). A multivariable regression model showed testing in accordance with guidelines significantly increased with government insurance (OR = 1.6, CI = 1.2-2.3), having a health maintenance visit in the preceding 26 months (OR = 2.4, CI = 1.4-4.1), family history of CRC (OR = 3.1, CI = 1.6-5.8), number of medical conditions (OR = 1.2 for each additional condition, CI = 1.1-1.3), high importance of screening to patient (OR = 2.6, CI = 1.5-4.5), patient satisfaction with doctor's discussions (OR = 3.3, CI = 2.2-4.8), physician trained in flexible sigmoidoscopy (OR = 2.3, CI = 1.6-3.4), and physician report of trying to follow American Cancer Society (ACS) guidelines (OR = 1.7, CI = 1.2-2.5). After excluding patients who had symptoms prior to screening, most of the ORs in the logistic regression analysis increased except that the number of medical conditions and physician trying to follow ACS guidelines became nonsignificant.

CONCLUSIONS: Fewer than half of rural patients received CRC testing, and most of those tested had symptoms. Physician recommendations and the manner of presenting the recommendations greatly influenced whether patients were tested.

Why hasn't this patient been screened for colon cancer?

Levy BT, Nordin T, Sinift S, Rosenbaum M, James PA (2007). An Iowa Research Network Study. Journal of the American Board of Family Medicine, 20(5), 458-68.

BACKGROUND: Less than half of eligible Americans have been screened for colorectal cancer (CRC). The objective of this study was to describe physicians' reasons for screening or not screening specific patients for CRC and their approach to CRC testing discussions.

METHODS: This study used mixed-methods. Physicians described their reasons for screening or not screening 6 randomly chosen patients who were eligible for CRC screening (3 screened and 3 not screened) whose CRC testing status was ascertained by medical record review. Verbatim transcripts from physicians responding to structured interview questions were used to identify themes. Specific elements of discussion were examined for their association with each physician's screening rate. Fifteen randomly chosen Iowa family physicians from the Iowa Research Network stratified by privileges to perform colonoscopy, flexible sigmoidoscopy, or neither procedure dictated the reasons why 43 patients were screened and 40 patients were not screened.

RESULTS: Reasons patients were not up to date fell into 2 major categories: (1) no discussion by physician (50%) and (2) patient refusal (43%). Reasons for no discussion included lack of opportunity, assessment that cost would be prohibitive, distraction by other life issues/health problems, physician forgetfulness, and expected patient refusal. Patients declined because of cost, lack of interest, autonomy, other life issues, fear of screening, and lack of symptoms. Patients who were up to date received (1) diagnostic testing (for previous colon pathology or symptoms; 56%) or (2) asymptomatic screening (44%). Physicians who were more adamant about screening had higher screening rates ($P < .05$; Wilcoxon rank sum). Physicians framed their recommendations differently ("I recommend" vs "They recommend"), with lower screening rates among physicians who used "they recommend" ($P = .05$; Wilcoxon rank sum).

CONCLUSIONS: Reasons many patients remain unscreened for CRC include (1) factors related to the health care system, patient, and physician that impede or prevent discussion; (2) patient refusal; and (3) the focus on diagnostic testing. Strategies to improve screening might include patient and physician education about the rationale for screening, universal coverage for health maintenance exams, and development of effective tracking and reminder systems. The words physicians choose to frame their recommendations are important and should be explored further.

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