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EDITORIAL

EDWARD H. WAGNER, MD, MPH
MacColl Institute for Healthcare Innovation
Seattle, Wash

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Quality Improvement Can't Be Optional

The Institute of Medicine has described the deficiencies in U.S. medical care as the "quality chasm."[1] This refers to the discrepancy between the type of care patients actually receive and the care that would be possible if patients were managed in accordance with the evidence. For a condition like depression, for example, the human dimensions of this quality chasm are enormous. Evidence from intervention studies suggests that about three fourths of depressed patients experience substantial reductions in depressive symptoms and disability if they receive appropriate therapy and if they are carefully monitored to assure treatment adherence and effectiveness.[2] Despite this evidence and the devastating human consequences of inadequately treated depression, estimates are that only about one fourth of all people with depression in the United States are effectively treated.[3]

What accounts for this chasm in depression? It is not for lack of efficacious therapy,[4] nor for lack of specific interventions that enable physicians to provide effective treatments. Depression management studies provide specific approaches to improving care, including collaborative care,[5] nurse case management,[6] and telephone follow-up[7], all of which have been shown to increase the effectiveness of treatment. Two recent trials combined these components into more comprehensive depression improvement programs that improved care and outcomes when they were implemented in busy practice settings.[8, 9] However, the interventions in these trials were designed, implemented, and financially supported by external research grants. Can similar results be achieved through local quality-improvement (QI) activities?

Quality Improvement in the Real World

Because of its importance in clinical practice, the strength of the evidence, and the availability of national guidelines,[10] depression management has been a common focus for QI. Three published trials have tested whether depression care could be improved in real-world practice settings through local application of industrial QI methods.[11–13] Despite the use of standard QI methods, these three trials demonstrated no improvement in depression care. The trial by Solberg and colleagues,[13] report-

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ed in this issue of **ecp**, is the most recent, the most disturbing, and perhaps the most revealing.

In the two earlier QI interventions,[11, 12] QI teams were given free rein in designing practice changes, which was in agreement with the then-prevailing QI philosophy. Predictably, the strategies selected were ones that required little change in current primary care practice and therefore were unlikely to have much impact on depression care. Further, the QI team reported by Brown and colleagues[12] apparently did not obtain the resources or support from senior management necessary to put their ideas into operation. It is therefore not surprising that these earlier efforts failed to improve care.

Why Did This Latest Intervention Fail?

The study by Solberg and colleagues is a different matter altogether. It describes a well-conceived intervention based on proven system change strategies[7–9] implemented through the use of modern QI methods involving small tests of change.[14] The new care-management system gave primary care practitioners ready access to mental health specialists and nurse case managers to ensure better patient follow-up and support.

The system that was put in place closely resembled other successful comprehensive depression QI programs,[8, 9] so if used, it was likely to make a difference. However, the new system had little impact on depression care and failed to improve depression outcomes. The reason for failure was crystal clear: Only one in eight study patients experienced the new system of care. Although it is possible that physicians did not find the new-order system intuitive to use (e.g., one physician is quoted in the paper as saying, "I couldn't remember the letters or what they stood for"), the investigators mainly attribute the lack of referrals to unsupportive physician attitudes and to lackluster support from clinical leadership.

System change requires hard work and access to resources, as it must overcome the powerful inertia of entrenched clinical and administrative routines. Without some degree of motivation among the involved practitioners and visible encouragement and support from senior leaders in removing barriers or garnering resources, achieving comprehensive system change is unlikely.

It is interesting to note that baseline study data showed that only one half of study participants had a follow-up visit in 3 months and less than one half showed evidence of improvement in depression. Despite these indicators of mediocre quality, the study physicians felt little need for improvement. Does this reflect ignorance of what is possible or a more generic defensiveness and resistance to change? QI can only be successful if practitioners understand the quality chasm, its roots in the system of care, and their ability to change it. In this study, perhaps the interventions were viewed as an "add-on"—one option of many available to clinicians. This interpretation is a harbinger of failure.

Make New Systems the Default

Chronic disease QI efforts only close the quality chasm if they become the new clinical routine—the default system of care—not just another option. For example, Solberg and colleagues might have created a system in which clinic clerks could not assign follow-up appointments for patients with depression until one of the depression management options was selected. The successful research programs described above[5–9] worked because they assured that the majority of patients experienced the new care system.

The new system of depression care so carefully constructed by the HealthPartners team unfortunately became optional, and the demands of busy clinical practice made it an infrequently chosen one. Of interest, referrals to the new system tended to come from the clinicians in the clinic of the only physician involved in the QI team. This highlights a common problem in QI: the difficulty of spreading enhancements beyond the practices of those motivated innovators involved in the initial improvement endeavor.[14] Strong leadership and continued testing and tailoring of changes are particularly critical in the process of diffusing improvements to less involved and motivated parts of the system.

Publication bias, which refers to the preference of investigators, journal reviewers, journal editors, and journal readers for positive results, ignores the results of a negative study. This is unfortunate, not only because it promotes inappropriately optimistic views of treatments or associations, but because negative studies may tell us as much or more about an issue as positive ones. For those interested in increasing the effectiveness of care for depressed people, the elegant failure of Solberg and colleagues should be required reading. They demonstrate that closing the quality chasm requires fundamental system change affecting the care of all patients.

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Correspondence

Edward H. Wagner, MD, MPH, Center for Health Studies, Group Health Cooperative, 1730 Minor Ave, Suite 1290, Seattle WA, 98101; telephone: 206-287-2877; fax: 206-287-2871; e-mail: wagner.e@ghc.org.