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Research Activities

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Surgery-related errors may adversely affect up to 3 percent of hospitalized patients

Surgery-related errors (adverse events) can result in patient death, disability, or a prolonged hospital stay. A new study shows that surgery-related errors adversely affected about 3 percent of patients admitted to hospitals in Colorado and Utah in 1992. How much the incidence of adverse events varies regionally is unknown, but this could represent a decline from previous incidence rates of 3.7 percent of New York admissions in 1984 and 4.6 percent of California hospital admissions in 1972.

In Utah and Colorado, two-thirds of all adverse hospital events were surgical, and nearly one in seven resulted in permanent disability or death. Furthermore, more than half of these were preventable, according to the study, which was supported in part by the Agency for Health Care Policy and Research (National Research Service Award training grant T32 HS00020).

Complications related to surgical technique, wound infections, and postoperative bleeding produced nearly half of all surgical adverse events; one-fourth of complications were related solely to surgical technique. Adverse events related to nonoperative aspects of care provided to surgical patients proved surprisingly important as well. Drug-related errors, diagnostic errors, and errors in choice of therapy accounted for 12 percent of surgical patients' adverse events.

Researchers led by Atul A. Gawande, M.D., of Brigham and Women's Hospital, reviewed the records of 15,000 nonpsychiatric hospital discharges in 1992 from a representative sample of hospitals from Utah and Colorado. They identified 12 operations with significantly elevated adverse event incidence rates that ranged from 4.4 percent for hysterectomy to 18.9 percent for abdominal aortic aneurysm repair. It was not clear why some operations resulted in high rates of injury. Further research is needed to identify strategies that will effectively reduce surgical adverse events.

For more details, see "The incidence and nature of surgical adverse events in Colorado and Utah in 1992," by Dr. Gawande, Eric J. Thomas, M.D., M.P.H., Michael J. Zinner, M.D., and Troyen A. Brennan, M.D., J.D., M.P.H., in the July 1999 *Surgery* 126(1), pp. 66-75. ■

Blood coagulation testing of pregnant women with hypertension can be reduced

High blood pressure or hypertension complicates 6 to 10 percent of pregnancies and can lead to a serious condition called preeclampsia. Preeclampsia may cause abnormal liver function, compromised kidney function, swelling due to fluid retention, alterations of electrolyte and fluid balance, and blood clotting deficiencies that put a pregnant woman at serious risk of hemorrhage. Severe preeclampsia can threaten the life of the mother and her baby.

Doctors often use several relatively expensive blood coagulation tests to diagnose preeclampsia in pregnant women with hypertension: prothrombin time (PT), partial thromboplastin time (aPTT), fibrinogen levels, or a combination of these tests. However, a normal blood platelet count plus a normal lactate dehydrogenase test can predict coagulation abnormalities and obviate the need for additional tests. This is true especially if there is no evidence of bleeding or other condition that could reduce the blood's ability to clot (coagulopathy), concludes a study supported by the Agency for Health Care Policy and Research (HS08131).

Researchers led by William M. Barron, M.D., of Loyola University Medical Center, searched laboratory records and charts at two Chicago academic medical centers for patients admitted between May and November 1993. They identified pregnant women tested for hypertension and then excluded conditions producing coagulopathy. Preliminary data on 73 women found that platelet count plus a lactate dehydrogenase test best predicted coagulation abnormalities.

Among the 30 percent of another 732 women who underwent additional coagulation tests, few had abnormal results, and very few had levels denoting significant risk of hemorrhage. The combination of a normal platelet count plus a normal lactate dehydrogenase test was able to predict no clinically significant abnormalities of PT and aPTT 100 percent of the time and no significant abnormalities of fibrinogen 99 percent of the time. These findings support published practice guidelines, none of which call for routine use of PT, aPTT, or fibrinogen in evaluation of women with hypertension complicating pregnancy.

More details are in "Reducing unnecessary coagulation testing in hypertensive disorders of pregnancy," by Dr. Barron, Paul Heckerling, M.D., Judith Hibbard, M.D., and Susan Fisher, Ph.D., in the September 1999 *Obstetrics and Gynecology* 94(3), pp. 364-370. ■

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Risks and benefits of hormone replacement therapy are not the only factors that women consider

Doctors advising postmenopausal women about hormone replacement therapy (HRT) typically mention the benefits of HRT to prevent cardiovascular disease and osteoporosis. They also note the slightly increased risk of breast cancer associated with HRT. But women have other concerns that enter into the HRT decision, such as whether HRT will help with sleep loss and genitourinary problems that often accompany menopause.

These issues also are not addressed by counseling guides used by doctors and developed by the American College of Physicians, American College of Obstetricians and Gynecologists, and the U.S.

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Preventive Services Task Force. What's more, women typically incorporate their doctor's opinion, media reports, and the experiences of friends and family when making the HRT decision, areas often left unmentioned in the guides. Women would find HRT counseling guides much more useful if they addressed these areas, concludes a preliminary study supported by the Agency for Health Care Policy and Research (National Research Service Award fellowship F32 HS00107).

Maureen T. Connelly, M.D., M.P.H., of Harvard Medical School, and her colleagues interviewed 26 women in a health maintenance organization who had received an initial prescription for HRT. On average, women reported 15 factors (range, 6 to 24 factors) as critical to their HRT decision, whereas the guides produced by these three organizations only addressed 6 factors. Although most women cited their doctor's opinion (96 percent), reports in the media (81 percent), and experiences and opinions of friends (77 percent) as critical to their HRT decision, counseling recommendations addressed none of these concerns.

Only one guide acknowledged the powerful effect that the doctor's opinion may have on patient decisionmaking. None of the guides addressed the ability of HRT to decrease sleep disturbance and genitourinary problems, even though more than half of the women studied said that these problems strongly influenced their decision about HRT. None of the guides suggested that clinicians explore patients' exposure to HRT media reports or experiences of friends and family, either to challenge or verify the information.

See "Patient-identified needs for hormone replacement therapy counseling: A qualitative study," by Dr. Connelly, Nancy Ferrari, A.B., Nicole Hagen, B.A., M.H.S., and Thomas S. Inui, Sc.M., M.D., in the August 1999 *Annals of Internal Medicine* 131(4), pp. 265-268. ■

Children's Health

Predicting which infants with RSV infection will need intensive care continues to be difficult

Respiratory syncytial virus (RSV) is a common cause of bronchiolitis and pneumonia in young children and can cause serious breathing problems. Previously healthy infants who become infected with RSV generally don't deteriorate to the point that they need intensive care. In fact, a new study shows that only 2 percent of these infants had to be transferred to the pediatric intensive care unit (PICU) for closer monitoring of progressive respiratory distress. However, it is difficult to predict which infants infected with RSV will require intensive care. Thus, they need to be cared for in a medical unit that has sufficient resources to provide careful observation and timely transfer of deteriorating infants to a PICU, conclude researchers from the University of Rochester School of Medicine, Rochester, NY.

In the study, which was supported in part by the Agency for Health Care Policy and Research (HS09062), Ann-Marie Brooks, M.D., John T. McBride, M.D., principal investigator Kenneth M. McConnochie, M.D., M.P.H., and colleagues examined the clinical signs and symptoms of 542 previously healthy, full-term, RSV-infected infants admitted to the Children's Hospital at Strong or Rochester General Hospital's general pediatric unit. They compared presenting signs and symptoms of infants who remained on the unit with those of the 2 percent of infants who were transferred to the PICU and found no significant differences. Infants transferred to the PICU had breathing problems that deteriorated

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RSV infection in infants

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over hours rather than minutes, and attending physicians' assessments led to PICU transfer.

Abnormally rapid breathing (respiratory rate greater than 80) and extreme oxygen deficiency (hypoxemia, oxygen saturation less than 85 percent) were both associated with subsequent respiratory deterioration. However, only a small proportion of infants who deteriorated initially showed these signs, limiting the ability of the signs to predict which infants would need intensive care. Upon admission to the emergency department (ED), infants eventually transferred to the PICU had only a modestly different mean respiratory rate (63 vs. 50) and oxygen saturation (88 vs. 93 percent) compared with those who were not admitted to the PICU. Wheezing and chest x-rays did not differ between the two groups.

See "Predicting deterioration in previously healthy infants hospitalized with respiratory syncytial virus infection," by Drs. Brooks, McBride, McConnochie, and others, in the September 1999 *Pediatrics* 104(3), pp. 463-467. ■

Good communication between doctors, parents, and children remains the cornerstone of high quality pediatric care

Good communication between doctors and parents and their children is an essential component of high-quality pediatric care. Fortunately, this is an area in which parents report few problems, according to a recently developed consumer survey. The Child Care Survey from the Consumer Assessment of Health Plans Study (CAHPS)® was designed to assess the interpersonal care of children based on parental responses. Field testing of the survey revealed that 3,083 Washington State employees who were insured through the State employee benefits program rated personal doctors most highly. They rated overall care and specialty care nearly as well and rated plan administration lowest. Parent-doctor and child-doctor communication, as well as spending sufficient time with the child, appeared most important to families in their assessments of overall care and of personal doctors.

Parents generally reported positive experiences with their child's health care. They rated their personal doctor's care as high quality (8.37 on a 0-10 scale), and they viewed the overall quality of care and care provided by their child's specialist only slightly less well (8.27 and 8.21, respectively). The mean overall rating of the health plan was lower (7.07). Almost all parents (88 percent) reported that it was easy to find a personal doctor among the plan's choices, and 82 percent indicated they were always or usually able to get help when they phoned their doctor.

Access to specialists was more difficult. Among those whose child needed to see specialists in the past 6 months, 13.4 percent reported the child was not able to see a specialist, and 25 percent noted it was not easy to get a specialty referral when needed. Performance in the more administrative aspects of health care, such as waiting times, was rated lower but did not influence the overall experience as strongly as the physician relationship, according to the researchers. Their work was supported in part by the Agency for Health Care Policy and Research (HS09205).

See "The Consumer Assessment of Health Plan Study (CAHPS)® survey of children's health care," by Charles J. Homer, M.D., M.P.H., Floyd J. Fowler, Ph.D., Patricia M. Gallagher, and others, in the July 1999 *Joint Commission Journal on Quality Improvemen*t 25(7), pp. 369-377. ■

Clinical Decisionmaking

Antibiotic treatment of Lyme disease depends on clinical signs and symptoms

Antibiotic treatment of Lyme disease (LD), which is transmitted by a bite from a deer tick, depends primarily on the patient's clinical signs and symptoms, according to a study supported by the Agency for Health Care Policy and Research (HS07813). Patients whose only symptom is a bulls-eye rash surrounding the tick bite (erythema migrans, EM) typically receive a 3-week course of doxycycline or amoxicillin. At the other extreme, 25 to 40 percent of patients with joint, neurologic,

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cardiac, or multiple extracutaneous symptoms or with systemic Lyme disease receive 2 to 3 weeks of intravenous ceftriaxone.The study was led by G. Thomas Strickland, M.D., Ph.D., of the University of Maryland School of Medicine.

Dr. Strickland and his colleagues studied Maryland State reporting forms completed by physicians to identify the antibiotics used to treat 1,601 patients (aged 1 to 92 years) diagnosed with LD by the reporting physician. They classified the patients into three groups: EM alone, EM and extracutaneous symptoms, and late manifestations of Lyme disease. Eighty-eight percent of the patients were treated initially with doxycycline, amoxicillin, or ceftriaxone; another 4 percent were treated with tetracycline. Eight-eight percent of the patients received one antibiotic, and about 12 percent were treated with two or more courses of antibiotics within 2 months following diagnosis.

Patients with EM alone were more apt to receive one course of antibiotic than those with extracutaneous symptoms, with or without EM. The average duration of the second course of oral antibiotic ranged from 21 days for those only having EM to 28 days for those having chronic manifestations. Intravenous ceftriaxone, which is significantly more expensive and potentially more toxic than oral doxycycline and amoxicillin, was used primarily for patients with joint, neurologic, and multiple extracutaneous manifestations (mean of 21 days) and for those with cardiac manifestations (mean of 15 days).

Details are in "Antibiotic therapy of Lyme disease in a population-based cohort," by César A. Peña, D.V.M., M.S., Anita A. Mathews, M.S., Nauman H. Siddiqi, M.S., and Dr. Strickland, in the September 1999 *Clinical Infectious Diseases* 29, pp. 694-695. ■

Market Forces

Business coalitions have the potential to buy health care quality as well as contain costs

A study by the Agency for Health Care Policy and Research and the National Business Coalition for Health (NBCH) suggests that most business coalitions—regional, State, and local groups of employers with common interests in health care coverage for their workers and dependents—have processes in place that could be tapped to promote quality, just as their market power helped contain health care costs earlier this decade by encouraging the growth of managed care. The study was led by Irene Fraser, Ph.D., director of AHCPR's Center for Organization and Delivery Studies.

The analysis, which was based on data from a 1998 NBCH survey of business coalitions and on interviews with nine coalition leaders, shows that many coalitions are involved in a broad range of activities designed to exert influence in the marketplace. Ninety percent of the 75 coalitions that participated in the survey said they collect or analyze data about health plans or providers, and nearly two-thirds of these said their involvement is extensive. Four of every five coalitions negotiate the terms of one or more health benefits with health plans, providers, or others. These benefits can range from narrowly defined services to comprehensive coverage. The most commonly negotiated services are narrowly defined speciality services, also known as carve-outs, such as prescription drug benefits, vision care, and psychiatric services.

Thirty-five percent of business coalitions bypass health plans and negotiate comprehensive coverage directly with providers. Almost six of every 10 coalitions that negotiate coverage, whether from health plans, providers, or purveyors of carve-out services, write performance incentives such as bonuses and premium rebates, and penalties such as withholding payment, into their contracts.

According to the authors, these incentives can be used to foster cost reduction and improved customer service, but they can also be used to encourage and reward good clinical care if the coalition chooses to use them that way. The real challenge—especially in the face of what appears to be an impending resurgence of rising health care costs—will be to use this market power for improving quality as well as containing costs.

For more information, see "Pursuit of quality by business coalitions: A national survey," by Dr. Fraser, Peggy McNamara, Gregg O. Lehman, Sandra Isaacson, and Kelli Moler, in the November-December 1999 issue of *Health Affairs* 18(6), pp. 158-165. Reprints (AHCPR Publication No. 00-R003) are available from AHCPR.** ■

Physician practice management companies offer relatively narrow benefits to affiliated medical groups

The proportion of physicians practicing in both single-specialty and multispecialty groups has increased in the past three decades, from less than 11 percent in 1965 to almost 35 percent in 1995. Physician practice management companies (PPMCs), which transfer ownership of a practice to public investors while maintaining significant equity control in the hands of a smaller number of physician group member-investors, offer certain narrow competitive advantages to these affiliated medical groups. This is the conclusion of a recent study that was supported in part by the Agency for Health Care Policy and Research (HS09536).

PPMCs provide a facilitating structure for accessing public equity, diversifying ownership risk, and "scaling up" the size of the defined populations for which physicians can assume capitated risk. However, PPMCs are not likely to deliver significant operating cost savings or revenue enhancements per unit of output, according to Douglas A. Conrad, Ph.D., of the University of Washington and his colleagues. Nor do these organizations as currently structured promise substantial coordination of care opportunities beyond those that medical groups and other provider organizations could achieve through cooperation and contracts with each other.

The relative financial and operating performance of the PPMCs during the past 2 years seems to favor the single-specialty companies over the multispecialty ones. Single-specialty companies are the fastest growing sectors of the PPMCs and appear to have the potential to achieve the greatest benefit from consolidation of physician practices. This is because the large number of small single-specialty practices offers relatively great opportunity for realizing incremental economies of scale. Will well-diversified stockholders encourage different economic and clinical behavior than physician owners? Probably not, according to Dr. Conrad, since the physicians retain sole clinical autonomy, and their reputation as the larger PPMC becomes as important as their group practice reputation.

See "Physician practice management organizations: Their prospects and performance," by Dr. Conrad, Shaun Koos, Alan Harney, and Martin Haase, in the September 1999 *Medical Care Research and Review* 56(3), pp. 307-339. ■

Health Care Costs and Financing

Community health centers need more resources to provide proper care to high-risk asthma patients

Federally funded community health centers (CHCs) care for many poor, high-risk asthma patients. Unfortunately, they often do not have the resources needed to follow current guidelines for optimal asthma care, according to a study supported in part by the Agency for Health Care Policy and Research (interagency agreement with the Bureau of Primary Health Care, Health Resources and Services Administration). For instance, 29 percent of CHCs surveyed in the Southeastern United States were unable to provide needed asthma medications for uninsured asthma patients.

To avoid unnecessary hospitalizations due to uncontrolled asthma, low-income and uninsured asthma patients must have affordable access to recommended treatments such as inhaled steroids, beta-agonist inhalers, and metered-dose inhaler spacing devices, as well as tools such as peak flow meters to measure and monitor their breathing capacity. But only a small proportion of CHCs surveyed could provide these, especially to uninsured children.

Investing in CHCs could improve asthma care and outcomes for as many as a quarter of a million of the highest risk asthma patients in the United States, conclude the authors of the study. They collected data on CHC clinicians, pharmacy services, and patient characteristics from 35 CHCs in 8 Southeastern States during a 1-year period. Sixty-two percent of patients had income below the poverty level, and almost 75 percent were uninsured or receiving Medicaid.

Current national guidelines for the treatment of asthma emphasize early use of antiinflammatory medication, especially steroid

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inhalers. Underuse of inhaled steroids has been associated with higher asthma hospitalization rates, and overuse of beta-agonist medication has been associated with increased asthma symptoms, morbidity, and death. Of the CHCs that provided medication to patients, 82 percent provided beta-agonist inhalers, but 46 percent provided no steroid inhalers to their patients. Also, 83 percent of CHCs provided no peak flow meters to their asthma patients, and 65 percent were unable to provide simple spacers to maximize the benefit of metered-dose inhalers. Drug samples were the most common resource that clinic sites used to treat low-income asthma patients.

More details are in "Asthma care in community health centers: A study by the Southeast Regional Clinicians' Network," by George S. Rust, M.D., M.P.H., Virgil Murray, B.S., Hector Octaviani, M.D., and others, in the *Journal of the National Medical Association* 91(7), pp. 398-403, 1999. ■

Providing insurance coverage will not automatically ensure that mental health treatment needs are met

Mental health and substance abuse disorders currently affect about one-fourth of all adults between the ages of 18 and 64. However, previous studies have shown that less than one-third of those with a mental disorder can be expected to receive treatment for their condition over the course of a year. If universal insurance coverage were to be provided, it is projected that the number of currently uninsured people with major mental disorders using mental health treatment would rise by 40 percent. Despite this projected increase, less than 50 percent of those with a severe mental disorder would use mental health services, according to a simulation model of universal coverage policy. Thus, while insurance coverage can substantially increase the demand for treatment, simply extending insurance coverage would not be sufficient to meet the need for treatment, concludes a study by Samuel H. Zuvekas, Ph.D., of the Agency for Health Care Policy and Research.

Dr. Zuvekas used data from the National Institute of Mental Health's Epidemiologic Catchment Area (ECA) Study (1980-1985), which identified large segments of the general population at risk for needing mental health treatment, and data from AHCPR's 1987 National Medical Expenditure Survey (NMES) to develop simulation models that quantified changes in the use of outpatient mental health treatment among adults aged 18 to 64 years. He simulated two major types of reform proposals: universal coverage of all the uninsured and coverage of only the uninsured poor and near poor, which is typical of many expansions of State Medicaid programs.

Universal coverage simulations based on the ECA model suggest there would be a 62 percent increase in the percentage of the uninsured using mental health services. However, uninsured individuals with any lifetime disorder would have a smaller (54 percent) increase in the probability of a mental health visit compared with an 80 percent increase among the uninsured who had no disorder in their lifetime. Simulations based on the NMES model suggest that when only the uninsured with family incomes under 200 percent of poverty are provided public insurance, expenditures may be slightly better targeted toward those with poor mental health status. About 76 percent of additional visits would be made by those with poor mental health under the more limited policy, compared with 71 percent under the universal coverage policy.

See "Health insurance, health reform and outpatient mental health treatment: Who benefits?" by Dr. Zuvekas, in the Summer 1999 *Inquiry* 36, pp. 127-146. Reprints (AHCPR Publication No. 99-R078) are available from AHCPR.* ■

Mental health/substance abuse carve-out programs substantially reduce costs for these services

Carve-out programs for special health conditions, such as mental health/substance abuse (MHSA) problems, are not included in a health insurance plan's covered services. Instead, they are covered under a separate contract known as a "carve-out." The insurer contracts with a specialty vendor to manage only the MHSA risk for all of the plan's enrollees within a single MHSA plan.

In 1992, the Massachusetts Group Insurance Commission (GIC) adopted a carve-out program to cover MHSA services. The GIC sought a soft capitation contract that exposed the vendor to a limited amount of financial risk to avoid providing the vendor with strong incentives to skimp on service provision. Still there was the incentive to perform well on the contract and to save the GIC a substantial amount of money.

The carve-out resulted in a 54 percent decrease in total episode costs for individuals with unipolar depression and a 33 percent decrease for those with substance dependence, according to a study supported in part by the Agency for Health Care Policy and Research (National Research Service Award training grant T32 HS00020). These savings were most likely due to the shift from traditional inpatient care to less intensive and less expensive partial hospitalization services and traditional outpatient care for people with unipolar depression, concludes Haiden A. Huskamp, Ph.D., of Harvard Medical School. He attributes this shift to two key changes in benefit design: the addition of partial hospitalization services for MHSA conditions, which previously had been uncovered, and the expansion of the outpatient MHSA benefit, which reduced copayments and removed the annual limits on use of outpatient services.

Without the pharmacy data, Dr. Huskamp could not determine whether the carve-out arrangement resulted in a shift away from facility and outpatient treatments toward use of psychotropic drugs, which were not the financial responsibility of the carve-out vendor. Nor was it clear whether the decreases in costs and shift in treatment sites resulted in more or less appropriate care. However, Dr. Huskamp cautions that disproportionate decreases in per-episode spending for individuals with severe MHSA conditions may be a cause for concern.

More details are in "Episodes of mental health and substance abuse treatment under a managed behavioral health care carve-out," by Dr. Huskamp, in the Summer 1999 *Inquiry* 36, pp. 147-161. ■

HIV/AIDS Research

Greater access to clinics reduces the risk of hospitalization for poor people with advanced HIV disease

Hospitalization of people infected with HIV is not only costly, it also exposes them to the risk of hospital-acquired infections and complications. Poor individuals with advanced HIV disease who visit clinics with extended hours or other accessibility features have 23 percent lower odds of being hospitalized than those who visit less accessible clinics. Also, patients followed in clinics with at least four accessibility features (expanded clinic hours, case management, availability of urgent care in the clinic, and rapid scheduling of appointments) have one-third lower odds of being hospitalized than those treated at clinics with only one accessibility feature.

Unfortunately, the most accessible clinics comprised only 27 percent of surveyed clinics and served only one-fifth of New York's Medicaid-insured patients with advanced HIV disease, according to a study supported by the Agency for Health Care Policy and Research (HS06465). Promoting clinic accessibility—for example, by extending clinic hours—may increase the cost of providing outpatient care. Yet these up-front costs may be far less than the expenditures required to treat hospitalized HIV patients, which are frequently borne by public hospitals, notes Christine Laine, M.D., of Thomas Jefferson University. Dr. Laine and her colleagues retrospectively analyzed the New York State Medicaid HIV/AIDS research database entries from 1984 through 1992. They also surveyed directors of clinics serving Medicaid enrollees in the State with advanced HIV

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Access to clinics for people with HIV

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disease to identify clinic features associated with a lower risk of hospitalization.

Nearly half of the 6,840 clinic patients studied were hospitalized during the year before AIDS diagnosis. Extended clinic hours, availability of health care providers for telephone consultation, and a clinic case manager (who can encourage regular followup and predict long-term care needs) were significantly associated with reduced hospitalization in the year before AIDS diagnosis. Difficulty in contacting providers or obtaining appointments at the time of need may hinder timely receipt of outpatient services and lead to conditions that require hospitalization, conclude the researchers.

See "Relationship between ambulatory care accessibility and hospitalization for persons with advanced HIV disease," by Dr. Laine, Leona Markson, Sc.D., Thomas R. Fanning, Ph.D., and Barbara J. Turner, M.D., M.S.Ed., in the *Journal of Health Care for the Poor and Underserved* 10(3), pp. 313-327, 1999. ■

AIDS patients fare much better in dedicated AIDS units and magnet hospitals compared with general hospital units

By 1988, 40 U.S. hospitals had established dedicated AIDS units, and one AIDS specialty hospital had opened. AIDS patients treated in dedicated AIDS units or nurse magnet hospitals have lower odds of dying within a month after admission, achieve greater satisfaction with their care, and receive care that meets professional standards. Nurse magnet hospitals emphasize nurse autonomy, nurse control over the practice setting, and good relations with physicians. Better nurse staffing, AIDS physician specialty services, and more organizational control by bedside nurses are the key to improved patient outcomes in specialized AIDS units and magnet hospitals, concludes Linda H. Aiken, Ph.D., R.N., of the University of Pennsylvania.

In a study supported in part by the Agency for Health Care Policy and Research (HS08603), Dr. Aiken and her colleagues compared differences in AIDS patients' 30-day mortality rates and care satisfaction in dedicated AIDS units, scattered-bed units in hospitals with and without dedicated AIDS units, and in magnet hospitals. The researchers obtained data on 1,205 patients in 40 units in 20 hospitals and on 820 of their nurses.

Compared with patients in conventional scattered-bed units, those in magnet hospitals had odds of dying that were lower by a factor of 0.40. Patients in dedicated AIDS units and scattered-bed units of hospitals with dedicated AIDS units had lower odds of dying by factors of 0.61 and 0.56, respectively. An additional nurse per patient day cut the odds of dying in 30 days by more than half. Even an increase of .25 nurse per patient day lowered by 20 percent the odds of dying within 30 days. The effect of having an AIDS specialty service was similarly pronounced. Patients whose physicians were not associated with an AIDS specialty service were roughly three times as likely to die in 30 days as patients whose physicians had such an association.

For more details, see "Organization and outcomes of inpatient AIDS care," by Dr. Aiken, Douglas M. Sloane, Ph.D., Eileen T. Lake, M.S.N., M.P.P., R.N., and others, in *Medical Care* 37(8), pp. 760-772. ■

Some HIV-infected patients feel their lives have improved since their diagnosis

Infection with the human immunodeficiency virus (HIV) that causes AIDS is a chronic and debilitating condition. Yet, according to a small preliminary study, 49 percent of HIV-infected patients said that their lives were currently better than before they contracted HIV infection. Apparently, spirituality played a strong role in their perception. Patients who said that their lives were better now were more likely to say they were "at peace with God and the universe" and to have stopped using injection drugs. These feelings were unrelated to stage of HIV disease, number of years since diagnosis, or whether the patient was receiving protease inhibitor therapy.

It was not clear whether patients attributed their life improvement to HIV infection. Discontinuing illicit drug use, qualifying for social services, or some other

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HIV-infected patients' quality of life

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coincident event could explain improved life satisfaction, surmises Joel Tsevat, M.D., M.P.H., of the University of Cincinnati Medical Center. With support from the Agency for Health Care Policy and Research (HS09103), Dr. Tsevat and his colleagues interviewed 51 HIV-infected patients at a regional HIV/AIDS center. Two-thirds of patients (65 percent) were already diagnosed with AIDS, one-third (31 percent) were asymptomatic, and 4 percent were symptomatic.

When asked how they felt their life was going, 71 percent of patients were mostly satisfied, pleased, or delighted; only 6 percent were mostly dissatisfied or unhappy. No patient felt that life was terrible. In addition, 41 percent of patients felt that life was staying about the same, and 47 percent felt that life was getting better. The remainder of patients felt that life was getting worse or did not know. Patients rated their health progressively worse if they had AIDS versus symptomatic or asymptomatic HIV infection. Yet on average, these patients strongly preferred longevity to excellent health. About 47 percent of patients were unwilling to trade any time in their present state of health for perfect health, and 14 percent were willing to trade, at most, 9 days of life expectancy for excellent health. These time-tradeoff scores did not differ between patients who had an AIDS diagnosis and patients who had not yet been diagnosed with AIDS.

See "The will to live among HIV-infected patients," by Dr. Tsevat, Susan N. Sherman, D.P.A., Judith A. McElwee, R.N., and others, in the August 3, 1999 *Annals of Internal Medicine* 131(3), pp. 194-198. ■

Rural Health

Rural and urban medical practices are more similar than different, with several notable exceptions

Washington State's rural and urban physicians tend to diagnose and treat similar problems. However, there are a couple of specialties with notable differences. Rural general surgeons are much more apt than their urban counterparts to care for patients with gastroenterologic diseases and to perform endoscopic procedures, such as gastroscopy, sigmoidoscopy, and colonoscopy. Rural obstetrician-gynecologists (OB-GYNs) have more visits out of their specialty domain–for example, hypertension and diabetes–than urban OB-GYNs. Rural general surgeons and OB-GYNs provide care for patients who in urban areas would be seeing other types of physicians. Thus, these rural physicians need training outside their traditional specialty areas so that they can provide their patients with optimal care, suggests a study supported in part by the Agency for Health Care Policy and Research (contract 290-93-0136).

Laura-Mae Baldwin, M.D., M.P.H., and her colleagues at the University of Washington's Rural Health Research Center used 1994 Medicare claims data to compare the number of patients, age and sex of patients, number of outpatient and inpatient visits, diagnosis clusters, and procedure frequency and type for board-certified rural and urban physicians in 12 medical specialties. Overall, 14.4 percent of physicians in the 12 specialties practiced exclusively in rural Washington, with great variation by specialty. Rural physicians saw larger numbers of elderly patients and had higher volumes of outpatient visits than urban physicians. Rural primary care physicians and general surgeons had higher rates of outpatient procedures than their urban counterparts.

Rural/urban differences in the characteristics of physicians and patients, the physicians' practice volumes, and the scope of diagnoses and procedures for some specialties raise questions about the quality and equity of care available to rural patients.

More details are in "Rural and urban physicians: Does the content of the Medicare practices differ?" by Dr. Baldwin, Roger A. Rosenblatt, M.D., M.P.H., Ronald Schneeweiss, M.D., and others, in the Spring 1999 *Journal of Rural Health* 15(2), pp. 240-251. ■

New Institute of Medicine study to examine privacy protection practices of institutional review boards

The Institute on Medicine (IOM) of the National Academy of Sciences will examine the ways that institutional review boards protect against the disclosure of personal health information in health services research projects, determine whether there are any current "best practices," and then develop broadly applicable recommendations on how institutional review boards can improve their current practices.

Because very little is known currently about the ways that these boards address privacy concerns, the IOM report will provide useful guidance to the Congress, the Department of Health and Human Services, and the research community as they consider options for improving patient privacy. The Agency for Health Care Policy and Research and the Department of Health and Human Service's Office of the Assistant Secretary for Planning and Evaluation are cofunding the project. The study is expected to be completed in the summer of 2000.

Institutional review boards (IRBs) are committees formed by universities and other research institutions to review federally funded research projects and research projects funded by other sources at institutions–mostly academic—that voluntarily submit their study applications. These committees possess the authority to approve, disapprove, suspend, or terminate previous approval of such research in order to protect the rights and welfare of human subjects. An IRB approval means the research has been reviewed and may be conducted at an institution within the constraints set forth by the board. However, not enough is known about how IRBs can adequately protect patients from potential harm resulting from the disclosure of personal health information in patient databases used in studies. Furthermore, the ways IRBs review health services research projects may vary.

The broad principles and best practices developed under this new initiative should inform the debate on how best to protect personal health information used in health services research. ■

Highlights from AHCPR's Health Care Research Scholars Program

This is the first article in a series focusing on the recent achievements of current and former scholars who received support for their research education from the Agency for Health Care Policy and Research through our National Research Service Award (NRSA) institutional training grants program.

We are very proud of the accomplishments and recognition received by these current and former students, as well as the accomplishments of their training programs and advisors. We look forward to sharing their news with you from time to time.

These features will provide a window into the future of health services research and the individuals who have already begun to lead the way toward meeting the new challenges we will face in the years ahead. If you are a current or former scholar whose research education was supported by AHCPR or its predecessor agency (the National Center for Health Services Research and Health Care Technology Assessment, NCHSR) and you would like to be mentioned in an upcoming issue of *Research Activities*, please send a message with appropriate information to our e-mail box: training@AHCPR.gov. In particular, we are eager to

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Highlights from scholars program

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hear about how your research findings have been translated into practice or how your research has affectedhealth care in the United States. We look forward to hearing from you.

This month we are focusing on the achievements of fellows and predoctoral candidates.

Achievements by Fellows

- Siran Koroukian, Ph.D. (Case Western Reserve University, 1995-1998) was awarded the 1999 Dekker Foundation Outstanding Student Award in Health Services Research.
- Sue Goldie, M.D., (Harvard, 1995-1997) was named the Outstanding Teacher of the Year while at Yale University School of Medicine as part of the Physician Associate Program in 1997. She also received the Larry Lynn Award from the Society of General Internal Medicine in 1998.
- Valerie King, M.D., M.P.H., (University of North Carolina at Chapel Hill, 1997-present). After just 1 year on a postdoctoral NRSA grant, Dr. King was awarded one of ten Atlantic Fellowships offered by the Commonwealth Fund. She is spending a year in England at Oxford studying health care and policy issues in the European Union countries.

Predoctoral Candidates

- Alyce Adams (Harvard University, 1997-1998) is the recipient of a 3-year graduate prize fellowship at Harvard. In addition, she received a Harvard Graduate School of Arts and Sciences summer fellowship for her preliminary dissertation research regarding tribal involvement in health care resource allocation on Native American reservations.
- Jill Lavigne (University of Rochester, 1994-1996) received an AHCPR dissertation grant entitled "Diabetes-related productivity: Significance and sensibility to medical management."
- Loel Solomon (Harvard University, 1996-1999) received the Jacob K. Javits Senate Fellowship while at Berkeley in the Masters' program. He was also a professional staff member to the Senate Committee on Labor and Human Resources where he was responsible for several key features of the comprehensive health reform bill reported by the Committee in the 103rd Congress.
- Michael Trisolini (Brandeis, 1995-1999) recently received an AHCPR dissertation grant for his work on health-related quality of life issues in dialysis.

Next month's issue of *Research Activities* will focus on research grants awarded to fellows and appointments of recent training program graduates. ■

Announcements

AHCPR seeks research proposals on strategies for eliminating minority health disparities

The Agency for Health Care Policy and Research plans over the next 5 years to establish up to four "centers of excellence" that will identify practical tools and strategies to eliminate racial and ethnic disparities in the health care system. The research conducted by these centers will go beyond simply documenting disparities by putting a new emphasis on understanding their underlying causes and developing strategies to eliminate them.

This AHCPR research program is a part of the U.S. Department of Health and Human Services' initiative on eliminating racial and ethnic disparities and the U.S. Surgeon General's Healthy People 2010 goal to eliminate disparities in health by the year 2010. Additional information on the Initiative and Healthy People 2010 is available at www.raceandhealth.hhs.gov.

AHCPR's research will focus on six clinical areas: infant mortality, cancer screening and management, cardiovascular disease, diabetes mellitus, HIV, and immunizations for both children and adults. The centers will focus on minority children and elderly people who are chronically ill because these groups are particularly vulnerable to the impact of disparities in health care treatment. Another research emphasis will be on clinical preventive services. Minority health services researchers and minority or minority-serving institutions are especially encouraged to apply for these grants.

AHCPR is committed to a long-term investment in research to make substantial contributions to eliminating disparities in health care. The Agency has completed funding of 11 MEDTEP (Medical Treatment Effectiveness Program) Research Centers on Minority Populations throughout the Nation to improve

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RFA on minority health

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the effectiveness of medical diagnosis and treatment and disseminate information to help both minority patients and their health care providers. More recently, AHCPR has set aside $3 million in research funds to focus on issues of access and quality of care for racial/ethnic minority populations.

The Agency expects that applicants will seek partnerships with change agents—such as payers, policymakers, provider groups, professional groups, and community organizations—in the health care community. These partnerships will help ensure that the research and implementation of findings will have a positive impact on health care practices, policies, and patient outcomes. Applicants are also expected to build on existing linkages with the communities and community organizations and to develop new relationships with those communities to guarantee their needs are being addressed in the research.

The Agency intends to fund two to four grants by September 1, 2000. From the first year's funding level of up to $4.35 million (depending on AHCPR's fiscal year 2000 budget, which was still uncertain at press time), the Agency is setting aside $850,000 for the study of clinical preventive services, $500,000 for the study of minority children, and $500,000 for the study of chronically ill minority elderly.

Interested investigators are encouraged to submit letters of intent by December 22, 1999; the deadline for applications is January 21, 2000.

For further details and application instructions, see "Understanding and Eliminating Minority Health Disparities," (RFA HS-00-003) in the October 20, 1999, *NIH Guide for Grants and Contracts* at www.grants.nih.gov/grants/guide/rfa-files/RFA-HS-00- 003.html and on AHCPR's Web site at www.ahcpr.gov/fund/ A companion piece, "AHCPR Guidelines for the Research Program Project Grant," is also on AHCPR's Web site. Copies of the Request for Applications (RFA HS-00-003), as well as application forms and instructions, are available from AHCPR's Publications Clearinghouse.* ■

AHSR issues call for abstracts for June 2000 meeting

Abstracts are due by January 14, 2000, for papers to be presented at the Association for Health Services Research's annual meeting to be held June 25-27, 2000, at the Westin Bonaventure in Los Angeles, CA. The theme of the upcoming meeting is "Research to action: Shaping the health system in the new millennium."

Abstracts are invited for three categories: paper presentations, panel sessions, and posters. Paper presentations are being organized into 10 themes: access/social determinants, behavioral health, challenges for the new millennium, care for children, coverage and insurance, managed care and markets, management/organization, Medicare/care for elderly, quality, outcomes/effectiveness, and workforce issues. Panel presentations and posters are not theme-related but may focus on any health services research topic. All abstracts undergo blind peer review, and those selected for a session or poster presentation will be included in disk or CD format for all conference participants.

To be considered, abstracts (disk and five paper copies) must be received by AHSR no later than January 14, 2000. Abstracts may not contain tables or graphs. Abstracts sent by fax or e-mail will not be considered. Send abstracts to Arnold Epstein, M.D., Conference Chair, Association for Health Services Research, 1130 Connecticut Avenue, N.W., Suite 700, Washington, DC 20036. Selections will be made and authors will be notified by March 24, 2000.

Contact AHSR at the above address or by phone at 202-223-2477 or at fax 202-835-8972 to request an abstract submission form and more information. Or, visit AHSR's Web site at www.ahsr.org for the latest meeting information. ■

AHCPR funds new projects

The following research project grants, cooperative agreements, and conference grants were funded recently by the Agency for Health Care Policy and Research. Readers are reminded that research findings usually are not available until a project is finished or nearing completion.

Research Projects/Cooperative Agreements

Access and quality of care for low-income adolescents
Project director: Elizabeth A. Shenkman, Ph.D.
Organization: University of Florida
Gainesville, FL
Project number: AHCPR grant HS10465
Project period: 9/30/99 to 9/29/02
First year funding: $385,067

Access to and outcomes of HIV care in the United States
Project director: Martin F. Shapiro, M.D., Ph.D.
Organization: RAND Corporation
Santa Monica, CA
Project number: AHCPR grant HS10227
Project period: 9/30/99 to 9/29/01
First year funding: $468,317

Acupuncture treatment of depression during pregnancy
Project director: Rachel Manber, Ph.D.
Organization: Stanford University
Stanford, CA
Project number: AHCPR grant HS09988
Project period: 9/30/99 to 9/29/01
First year funding: $347,795

Analysis of fee-for-service vs. managed care CSHCN
Project director: Janet B. Zimmerman, Ph.D.
Organization: Michigan Public Health Institute
Okemos, MI
Project number: AHCPR grant HS10441
Project period: 9/30/99 to 9/29/02
First year funding: $204,544

Automated assessments and the quality of diabetes care
Project director: John D. Piette, Ph.D.
Organization: Palo Alto Institute for Research
Palo Alto, CA
Project number: AHCPR grant HS10281
Project period: 9/30/99 to 9/29/03
First year funding: $260,484

Cause and effect of hospital distress and closure
Project director: Richard C. Lindrooth, Ph.D.
Organization: Northwestern University
Evanston, IL
Project number: AHCPR grant HS10730
Project period: 9/30/99 to 9/29/00
Funding: $123,312

Commercial telephone triage vs. physician on-call advice
Project director: Larry J. Baraff, M.D.
Organization: UCLA Emergency Medicine Center
Los Angeles, CA
Project number: AHCPR grant HS10604
Project period: 9/30/99 to 9/29/00
Funding: $302,388

Computerized quality-of-life assessment in low-literacy patients
Project director: Elizabeth A. Hahn, M.A.
Organization: ENH Research Institute
Evanston, IL
Project number: AHCPR grant HS10333
Project period: 9/30/99 to 9/29/01
First year funding: $332,092

Cultural relevance of a continuity of care measure
Project director: Norma C. Ware, Ph.D.
Organization: Harvard Medical School
Boston, MA
Project number: AHCPR grant HS10335
Project period: 9/30/99 to 9/29/01
First year funding: $202,889

Dealing with publication bias in meta-analysis
Project director: Norma C. Terrin, Ph.D.
Organization: New England Medical Center
Boston, MA
Project number: AHCPR grant HS10254
Project period: 9/30/99 to 9/29/01
First year funding: $121,981

Detailed profile of end-of-life care in Medicare
Project director: Dorcas J. Lynn, M.D.
Organization: George Washington University
Washington, DC
Project number: AHCPR grant HS10561
Project period: 9/30/99 to 9/29/01
First year funding: $445,557

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New grants

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Do urine tests increase chlamydia screening in teens?
Project director: Mary-Ann Shafer, M.D.
Organization: University of California
San Francisco, CA
Project number: AHCPR grant HS10537
Project period: 9/30/99 to 9/29/02
First year funding: $520,154

Evaluating a decision tool for prenatal testing
Project director: Miriam Kuppermann, Ph.D.
Organization: University of California
San Francisco, CA
Project number: AHCPR grant HS10214
Project period: 9/30/99 to 9/29/02
First year funding: $492,887

Evaluating quality improvement strategies
Project director: Charles Jay Homer, M.D.
Organization: Children's Hospital
Boston, MA
Project number: AHCPR grant HS10411
Project period: 9/30/99 to 9/29/02
First year funding: $306,142

Evaluation of Kansas Healthwave
Project director: Robert F. St. Peter, M.D.
Organization: Kansas Health Institute
Topeka, KS
Project number: AHCPR grant HS10536
Project period: 9/30/99 to 9/29/02
First year funding: $161,388

Evidence-based practice: From book to bedside
Project director: Marita Titler, Ph.D.
Organization: University of Iowa
Iowa City, IA
Project number: AHCPR grant HS10482
Project period: 9/30/99 to 9/29/02
First year funding: $518,007

Evidence-based "reminders" in home health care
Project director: Penny H. Feldman, M.D.
Organization: State University of New York
New York, NY
Project number: AHCPR grant HS10542
Project period: 9/30/99 to 3/30/02
First year funding: $354,276

Evidence-based surfactant therapy for preterm infants
Project director: Jeffrey D. Horbar, M.D.
Organization: University of Vermont
College
Burlington, VT
Project number: AHCPR grant HS10528
Project period: 9/30/99 to 9/29/02
First year funding: $570,955

Facility effects on racial differences in nursing home quality
Project director: Mary L. Fennell, Ph.D.
Organization: Brown University
Providence, RI
Project number: AHCPR grant HS10322
Project period: 9/30/99 to 9/29/01
First year funding: $267,079

Health care access quality and insurance for CSHCN
Project director: Nancy L. Swigonski, M.D.
Organization: Indiana University
Indianapolis, IN
Project number: AHCPR grant HS10453
Project period: 9/30/99 to 9/29/02
First year funding: $388,351

Health outcomes for uninsured older adults
Project director: David W. Baker, M.D.
Organization: Case Western Reserve
University
Cleveland, OH
Project number: AHCPR grant HS10283
Project period: 9/30/99 to 9/29/01
First year funding: $138,950

Hospital industry restructuring: Impact on safety net
Project director: Larry M. Manheim, Ph.D.
Organization: Northwestern University
Evanston, IL
Project number: AHCPR grant HS10040
Project period: 9/30/99 to 9/29/01
First year funding: $211,455

Hospital performance and beta-blocker use after AMI
Project director: Harlan M. Krumholz, M.D.
Organization: Yale University
New Haven, CT
Project number: AHCPR grant HS10407
Project period: 9/30/99 to 9/29/02
First year funding: $416,489

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New grants

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Identification of clinically relevant changes in health-related quality of life
Project director: Fredric D. Wolinsky, Ph.D.
Organization: Saint Louis University
St. Louis, MO
Project number: AHCPR grant HS10234
Project period: 9/30/99 to 9/29/03
First year funding: $735,360

Impact of publicly funded programs on child safety nets
Project director: Peter P. Budetti, J.D., M.D.
Organization: Northwestern University
Evanston, IL
Project number: AHCPR grant HS10423
Project period: 9/30/99 to 9/29/02
First year funding: $330,874

Impact of a telecommunication system in childhood asthma
Project director: Robert H. Friedman, M.D.
Organization: Boston Medical Center
Boston, MA
Project number: AHCPR grant HS10630
Project period: 9/30/99 to 9/29/03
First year funding: $635,427

Implementation of computer-based health support systems
Project director: David H. Gustafson, Ph.D.
Organization: University of Wisconsin
Madison, WI
Project number: AHCPR grant HS10246
Project period: 9/30/99 to 9/29/03
First year funding: $568,920

Improving diabetes care collaboratively in the community
Project director: Marshall H. Chin, M.D., M.P.H.
Organization: University of Chicago
Chicago, IL
Project number: AHCPR grant HS10479
Project period: 9/30/99 to 9/29/02
First year funding: $428,176

Improving heart failure care in minority communities
Project director: Jane E. Sisk, Ph.D.
Organization: Mount Sinai School of Medicine
New York, NY
Project number: AHCPR grant HS10402
Project period: 9/30/99 to 9/29/02
First year funding: $696,691

Inguinal hernia management: Watchful waiting vs. operation
Project director: Robert J. Fitzgibbons, M.D.
Organization: American College of Surgeons
Chicago, IL
Project number: AHCPR grant HS09860
Project period: 9/30/99 to 9/29/04
First year funding: $1,355,621

Measuring patient satisfaction: Low-literacy populations
Project director: Judy Shea, Ph.D.
Organization: University of Pennsylvania
Philadelphia, PA
Project number: AHCPR grant HS10299
Project period: 9/30/99 to 9/29/02
First year funding: $392,072

Measuring quality of care for diabetes
Project director: Jack Needleman, Ph.D.
Organization: Harvard University
Cambridge, MA
Project number: AHCPR grant HS10332
Project period: 9/30/99 to 9/29/01
First year funding: $266,633

Measuring quality of care for high-risk infants
Project director: Jeannette A. Rogowski, Ph.D.
Organization: RAND Corporation
Santa Monica, CA
Project number: AHCPR grant HS10328
Project period: 9/30/99 to 9/29/02
First year funding: $368,235

Measuring quality of care for vulnerable children
Project director: Michael Seid, M.D.
Organization: Children's Hospital Research Center
San Diego, CA
Project number: AHCPR grant HS10317
Project period: 9/30/99 to 9/29/01
First year funding: $464,594

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New grants

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Medicaid vs. premium subsidy: Oregon's CHIP alternatives
Project director: Janet B. Mitchell, Ph.D.
Organization: Center for Health Economics Research
Waltham, MA
Project number: AHCPR grant HS10463
Project period: 9/30/99 to 9/29/02
First year funding: $176,378

Medical outcomes in the pricing of hospital procedures
Project director: Avi Dor, Ph.D.
Organization: National Bureau of Economic Research
Cambridge, MA
Project number: AHCPR grant HS10282
Project period: 9/30/99 to 9/29/02
First year funding: $174,758

New York's SCHIP: What works for vulnerable children?
Project director: Peter Szilagyi, M.D.
Organization: Rochester University
Rochester, NY
Project number: AHCPR grant HS10450
Project period: 9/30/99 to 9/29/02
First year funding: $478,512

Nursing home care at the end of life: Cost and quality
Project director: Vincent Mor, Ph.D.
Organization: Brown University
Providence, RI
Project number: AHCPR grant HS10549
Project period: 9/30/99 to 9/29/01
First year funding: $313,772

Organizational determinants of HIV care improvement
Project director: Paul D. Cleary, M.D., Ph.D.
Organization: Harvard Medical School
Boston, MA
Project number: AHCPR grant HS10408
Project period: 9/30/99 to 9/29/02
First year funding: $846,888

Panel-based pain management in primary care
Project director: Tim A. Ahles, Ph.D.
Organization: Dartmouth College
Hanover, NH
Project number: AHCPR grant HS10264
Project period: 9/30/99 to 9/29/02
First year funding: $590,896

Patient-centered quality measure for Asian-Americans
Project director: Russell S. Phillips, M.D.
Organization: Beth Israel Deaconess Medical Center
Boston, MA
Project number: AHCPR grant HS10316
Project period: 9/30/99 to 9/29/02
First year funding: $334,420

Patient preferences for disclosure: A national survey
Project director: Wendy Levinson, M.D.
Organization: University of Chicago
Chicago, IL
Project number: AHCPR grant HS09982
Project period: 9/15/99 to 8/31/03
First year funding: $393,982

Pediatric emergency care: Severity and quality
Project director: Murray M. Pollack, M.D.
Organization: Children's Research Institute
Washington, DC
Project number: AHCPR grant HS10238
Project period: 9/30/99 to 9/29/01
First year funding: $425,733

Persons with disabilities: Quality of care/service use
Project director: Lisa I. Iezzoni, M.D.
Organization: Beth Israel Deaconess Medical Center
Boston, MA
Project number: AHCPR grant HS10223
Project period: 9/30/99 to 9/29/02
First year funding: $299,716

Practice profiling to increase tobacco cessation
Project director: Susan H. Swartz, M.D.
Organization: Maine Medical Assessment Foundation
Manchester, ME
Project number: AHCPR grant HS10510
Project period: 9/30/99 to 9/29/02
First year funding: $188,636

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New grants

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Prescription benefits as a quality measure
Project director: Barry G. Saver, M.D.
Organization: University of Washington
Seattle, WA
Project number: AHCPR grant HS10318
Project period: 9/30/99 to 9/29/01
First year funding: $371,244

Provider participation and access in Alabama and Georgia
Project director: Janet M. Bronstein, Ph.D.
Organization: University of Alabama
Birmingham, AL
Project number: AHCPR grant HS10435
Project period: 9/30/99 to 9/29/02
First year funding: $475,188

Quality measurement in residential care
Project director: Catherine M. Hawes, Ph.D.
Organization: Menorah Park Center for the Aging
Beachwood, OH
Project number: AHCPR grant HS10315
Project period: 9/30/99 to 9/29/02
First year funding: $254,319

Quality measures for severe/persistent mental illness
Project director: Richard C. Hermann, M.D.
Organization: Harvard Medical School
Boston, MA
Project number: AHCPR grant HS10303
Project period: 9/30/99 to 9/29/01
First year funding: $256,612

Quality of hypertension care for Asian refugees
Project director: Candice C. Wong, Ph.D.
Organization: University of California
San Francisco, CA
Project number: AHCPR grant HS10276
Project period: 9/30/99 to 9/29/01
First year funding: $243,362

Reducing antimicrobial resistance: A randomized trial
Project director: Richard Platt, M.D., Ph.D.
Organization: Harvard Pilgrim Health Care
Boston, MA
Project number: AHCPR grant HS10247
Project period: 9/30/99 to 9/29/04
First year funding: $624,719

Strategies for CQI: A national randomized trial
Project director: T.B. Ferguson, M.D.
Organization: Society of Thoracic Surgeons
Chicago, IL
Project number: AHCPR grant HS10403
Project period: 9/30/99 to 9/29/02
First year funding: $469,662

Using census data to monitor care to vulnerable groups
Project director: Kevin Fiscella, M.D.
Organization: Highland Hospital
Rochester, NY
Project number: AHCPR grant HS10295
Project period: 9/30/99 to 9/29/01
First year funding: $112,359

Small Grants

Automated telephone preoperative assessment development
Project director: David J. Mingay, Ph.D.
Organization: University of Chicago
Chicago, IL
Project number: AHCPR grant HS10361
Project period: 9/30/99 to 9/29/00
Funding: $75,500

Cancer patients' atitudes toward cancer trials
Project director: Peggy A. Schuber, M.S.N.
Organization: University of Texas Health Science Center
Houston, TX
Project number: AHCPR grant HS10583
Project period: 9/30/99 to 11/30/00
Funding: $32,296

Computer-based documentation and provider interaction
Project director: Kevin B. Johnson, M.D.
Organization: Johns Hopkins University
Baltimore, MD
Project number: AHCPR grant HS10363
Project period: 9/30/99 to 9/29/00
Funding: $82,000

Cultural competence in acute hospital systems
Project director: Iris Garcia-Caban, B.S.
Organization: Brandeis University
Waltham, MA
Project number: AHCPR grant HS10567
Project period: 9/30/99 to 9/29/00
Funding: $32,400

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New grants

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Domestic violence assessment and intervention
Project director: Jacqueline Dienemann, Ph.D.
Organization: Georgetown University School of Nursing
Washington, DC
Project number: AHCPR grant HS10731
Project period: 9/30/99 to 3/30/01
Funding: $77,007

Dynamic stochastic model of investment in health
Project director: Ahmed Khwaja, M.A.
Organization: University of Minnesota
Minneapolis, MN
Project number: AHCPR grant HS10574
Project period: 9/30/99 to 9/29/00
Funding: $31,155

ED triage instrument to predict resource needs/ outcomes
Project director: Richard C. Wuerz, M.D.
Organization: Brigham and Women's Hospital
Boston, MA
Project number: AHCPR grant HS10381
Project period: 9/30/99 to 9/29/00
Funding: $84,733

Evaluation of safety data reporting in randomized trials
Project director: Joseph Lau, M.D.
Organization: New England Medical Center
Boston, MA
Project number: AHCPR grant HS10345
Project period: 9/30/99 to 9/29/00
Funding: $78,930

Health implications of welfare to work for women
Project director: Shawn M. Kneipp, Ph.D.
Organization: University of Florida College of Nursing
Gainesville, FL
Project number: AHCPR grant HS10727
Project period: 9/30/99 to 9/29/00
Funding: $26,432

Health-related quality of life issues in dialysis
Project director: Michael Trisolini, M.B.A.
Organization: Brandeis University
Waltham, MA
Project number: AHCPR grant HS10580
Project period: 9/30/99 to 7/30/00
Funding: $32,400

Health utilities in hepatitis C-infected patients
Project director: Kenneth Sherman, Ph.D.
Organization: University of Cincinnati
Cincinnati, OH
Project number: AHCPR grant HS10366
Project period: 9/30/99 to 9/29/00
Funding: $76,072

Hospital profiling of maternity length of stay
Project director: Denise Giles, M.P.H.
Organization: University of Alabama
Birmingham, AL
Project number: AHCPR grant HS10569
Project period: 9/30/99 to 9/29/00
Funding: $32,400

Household demand for employer-based health insurance
Project director: Jean Abraham, B.A.
Organization: Carnegie Melon University
Pittsburgh, PA
Project number: AHCPR grant HS10572
Project period: 9/30/99 to 1/31/01
Funding: $32,400

Impact of clinical pathways for rehabilitation care
Project director: Deborah G. Dobrez, Ph.D.
Organization: Northwestern University
Evanston, IL
Project number: AHCPR grant HS10375
Project period: 9/30/99 to 9/29/00
Funding: $73,482

Implementing family programs in psychiatric settings
Project director: Linda E. Rose, Ph.D.
Organization: Johns Hopkins University
Baltimore, MD
Project number: AHCPR grant HS10378
Project period: 9/30/99 to 9/29/00
Funding: $82,000

Meanings of race, class, and gender in heart disease
Project director: Janet K. Shim, M.P.P.
Organization: University of California
San Francisco, CA
Project number: AHCPR grant HS10582
Project period: 9/30/99 to 2/28/01
Funding: $31,096

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New grants

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Quality health outcomes: Satisfaction and adherence
Project director: Doris C. Vahey, M.A.
Organization: University of Wisconsin
Madison, WI
Project number: AHCPR grant HS10581
Project period: 9/30/99 to 9/29/00
Funding: $32,239

Quality information-consumer preference for health plans
Project director: Katherine M. Harris, Ph.D.
Organization: RAND Corporation
Santa Monica, CA
Project number: AHCPR grant HS10367
Project period: 9/30/99 to 9/29/00
Funding: $61,817

Seeking and denying antibiotic treatment in pediatrics
Project director: Tanya J. Stivers, M.A.
Organization: University of California
Los Angeles, CA
Project number: AHCPR grant HS10577
Project period: 9/30/99 to 8/31/00
Funding: $32,036

Spanish health messages: Are they reaching their target?
Project director: Holly E. Jacobson, Ph.D.
Organization: University of Arizona
Tucson, AZ
Project number: AHCPR grant HS10562
Project period: 9/30/99 to 9/29/00
Funding: $32,160

"Take-up rates": Who declines employer health insurance?
Project director: Catherine Desroches, M.S.
Organization: Columbia University
New York, NY
Project number: AHCPR grant HS10576
Project period: 9/30/99 to 1/31/00
Funding: $19,926

Trial of two decision aids for colon cancer screening
Project director: James G. Dolan, M.D.
Organization: Unity Health System
Rochester, NY
Project number: AHCPR grant HS10728
Project period: 9/30/99 to 9/29/00
Funding: $52,409

Use of erythropoietin: A survey of ASCO and ASH
Project director: Charles Bennett, M.D., Ph.D.
Organization: Northwestern University
Evanston, IL
Project number: AHCPR grant HS10370
Project period: 9/30/99 to 9/29/00
Funding: $57,530

Primary care fellowship evaluation
Project director: Diane Brannon, Ph.D.
Organization: Pennsylvania State University
University Park, PA
Project number: AHCPR grant HS10714
Project period: 9/30/99 to 9/29/00
Funding: $67,775

Psychosocial interventions for metastatic breast cancer
Project director: Ruvanee Pietersz, M.A.
Organization: University of Chicago
Chicago, IL
Project number: AHCPR grant HS10565
Project period: 9/30/99 to 9/29/00
Funding: $31,579

Conference Grants

Developing a Latino health agenda for 2010
Project director: Hector Balcazar, Ph.D.
Organization: Arizona State University
Tempe, AZ
Project number: AHCPR grant HS10079
Project period: 9/30/99 to 9/29/00
Funding: $19,200

Managing healthcare information
Project director: Kathleen Gersowitz, M.B.A.
Organization: State University of New York
Albany, NY
Project number: AHCPR grant HS10078
Project period: 9/15/99 to 2/15/00
Funding: $10,000 ■

Allison, J.J., Kiefe, C.I., Weissman, N.W., and others. (1999). "The art and science of searching MEDLINE to answer clinical questions." (AHCPR grants HS09446 and HS08843). *International Journal of Technology Assessment in Health* Care 15(2), pp. 281-296.

This article provides a brief tutorial on how to search the National Library of Medicine's MEDLINE database. The authors summarize the current state of the art of searching and provide an approach to enhance search skills. For example, they suggest general principles that can be applied to the constantly appearing new search engines. They propose an idealized classification system for the results of a MEDLINE search: Type A searches produce a few articles of high quality that are directly focused on the immediate question. Type B searches yield a large number of articles, some more relevant than others. Type C searches produce few or no articles, and those that are located are not germane. Provided that relevant, high-quality articles do exist, type B and C searches often may be improved with attention to search technique, according to the authors. They advise the searcher on how to overcome barriers to good searching, such as failure to begin with a well-built question or failure to apply proper limits to the search.

Barnett, S., and Franks, P. (1999, November). "Telephone ownership and deaf people: Implications for telephone surveys." (AHCPR grant HS09539). *American Journal of Public Health* 89, pp. 1754-1756.

People with hearing loss represent slightly more than 9 percent of the U.S. population, which is more than 23 million people. Of those, about 4.8 million people cannot hear or understand normal speech and instead use American Sign Language. This is the third most commonly used language in the United States, after English and Spanish. This study concludes that telephone surveys risk marginalizing prelingually deafened adults (those who lost hearing before they acquired language) due to low telephone ownership and language barriers. The researchers analyzed the Hearing Supplement of the National Health Interview Survey data from 1990 and 1991 to determine the prevalence of telephone ownership in different deaf populations. They found that, compared with the general population, prelingually deafened adults were less likely to own a telephone (adjusted odds ratio, AOR of 0.35; 1 is equal odds), whereas postlingually deafened adults (those who became deaf after they learned how to speak) were as likely as members of the general population to own a telephone (AOR of 1).

Lohr, K.N., and Carey, T.S. (1999, September). "Assessing 'best evidence': Issues in grading the quality of studies for systematic reviews." (AHCPR contract 290-97-0011). *Joint Commission Journal on Quality Improvement* 25(9), pp. 470-479.

Evidence-based medicine, clinical practice guidelines, quality and value of health services, and science-based decisionmaking are becoming mainstays of the health care sector. This movement toward the use of "best evidence," usually called evidence-based medicine or evidence-based practice, has spread widely in the United States and abroad during the past decade. As part of this movement, systematic reviews of clinical questions are becoming increasingly common. These systematic, evidence-based reviews are innovative in their comprehensive review of the literature, use of standard methods of presenting data, and special emphasis on the validity of research methods. These authors contend that, even in the absence of any universal evidence-grading system, those conducting systematic reviews of studies can take certain steps to ensure that their approaches to grading the quality of articles meet applicable scientific standards. To clarify issues in this area, in 1998 the Agency for Health Care Policy and Research commissioned a small project to determine how its 12 Evidence-based Practice Centers were carrying out this part of their systematic reviews (evidence reports). As part of this project, methods to grade the quality of research articles were developed and are reported in this article.

Mandelblatt, J.S., Ganz, P.A., and Kahn, K.L. (1999, August). "Proposed agenda for the measurement of quality-of-care outcomes in oncologic practice." (AHCPR grant HS08395). *Journal of Clinical Oncology* 17(8), pp. 2614-2622.

The Institute of Medicine recently released a report reviewing the quality of cancer care in the United States and called for further development and monitoring of quality indicators. More practice-based measures of quality cancer care are needed as we move into the 21st

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Research briefs

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century, note these researchers. They reviewed methodological concerns involved in selecting quality of care measures, using breast cancer to exemplify key issues from early detection through posttreatment surveillance. They give examples of potential breast health care outcome measures, including the use of charts and tumor registries to track stages of cancer over time and rate of true-positive breast biopsies for screening and diagnosis indicators. They define criteria for measures of the quality of breast cancer care. These measures should capture a condition or aspect of a condition that has a large burden of morbidity or mortality in the target population, be sufficiently prevalent in the setting/unit of interest (for example, practice or region), be under the control of patients and providers (that is, be amenable to change), and be feasible to collect and verify in routine practice settings.

Meenan, R.T., O'Keefe-Rosetti, M.C., Hornbrook, M.C., and others. (1999). "The sensitivity and specificity of forecasting high-cost users of medical care." (AHCPR National Research Service Award training grant T32 HS00069 and fellowship F32 HS00072). *Medical Care* 37(8), pp. 815-823.

This study demonstrates the potential of risk-assessment models to inform care management decisions by efficiently screening managed care populations for high-expense risk. Such models can act as preliminary screens for plans that can refine model forecasts with detailed surveys, suggest the authors. They analyzed 98,985 cases drawn randomly from memberships of 3 staff/group health plans. They measured risk-factor data from 1992 and measured expenses for 1993 and then compared the ability of three risk-assessment models,—the Global Risk Assessment Model (GRAM), a logistic version of GRAM, and a prior-expense model—to analyze the models' ability to distinguish high and low expense-risk status. All models forecast the highest cost cases relatively well. The authors conclude that such models can inform care management decisions by efficiently screening managed care populations for high expense-risk. ■

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