



Research Activities



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Preventive Services Task Force issues caution on combined hormone therapy

The U.S. Preventive Services Task Force has recommended against the use of combined estrogen and progestin therapy for preventing cardiovascular disease and other chronic conditions in postmenopausal women. The Task Force, which is sponsored by the Agency for Healthcare Research and Quality, issued the recommendation in mid-October.

The Task Force found evidence for both benefits and harms of combined estrogen and progestin therapy, one of the most commonly prescribed hormone regimens. However, they concluded that harmful effects of the combined therapy are likely to exceed the chronic disease prevention benefits for most women.

The Task Force further concluded that the evidence is insufficient to recommend for or against the use of estrogen alone for prevention of chronic conditions in postmenopausal women who have had a hysterectomy. A study of estrogen therapy in women who have had hysterectomies is continuing as part of the National Institutes of

Health's Women's Health Initiative (WHI) because it has not yet found clear benefit or harm. Estrogen alone, or estrogen and progestin together, are commonly referred to as hormone therapy or hormone replacement therapy.

On October 23-24, the National Institutes of Health held a scientific workshop to review the results from one component of the WHI clinical trial in the context of other completed and ongoing federally funded research on menopausal combination hormone therapy. In the near future, the Food and Drug Administration will host a public session on this topic.

An estimated 14 million American women take hormone therapy to help relieve hot flashes and other menopausal symptoms, as well as to prevent chronic conditions such as heart disease. Heart disease is the leading cause of death among U.S. women. The use of hormone therapy to treat hot flashes or other symptoms of menopause was not evaluated by the Task Force. The Task Force concluded that women considering

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Combined hormone therapy

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starting or continuing hormone therapy to relieve menopausal symptoms should discuss their individual risks for specific chronic conditions and personal preferences with their clinician.

The scientific review for the Task Force examined hundreds of studies, including a recently terminated trial within the NIH's Women's Health Initiative, which reported the effects of taking combined estrogen and progestin therapy on a variety of chronic diseases. The Task Force concluded that combined hormone therapy could increase bone mineral density and reduce the risk of fractures and may reduce the risk of colorectal cancer. They found equally strong evidence, however, that combined hormone therapy increases the risk for breast cancer, blood clots, stroke, and gallbladder disease. In addition, evidence reviewed by the Task Force suggests that hormone therapy does not reduce the risk of heart disease, and that combined

estrogen and progestin actually increases the risk of heart attacks. The effects of hormone therapy on dementia, cognitive function, and ovarian cancer are uncertain.

The Task Force is the leading independent panel of private-sector experts in prevention and primary care. The Task Force conducts rigorous, impartial assessments of all the scientific evidence for a broad range of preventive services, and its recommendations are considered the gold standard for clinical preventive services. The Task Force based its conclusion on a report from a team led by Heidi Nelson, M.D., M.P.H., and Linda Humphrey, M.D., M.P.H., from AHRQ's Evidence-based Practice Center at Oregon Health & Science University in Portland. These reports were published in the August 20, 2002, *Annals of Internal Medicine* and the August 21, 2002, *Journal of the American Medical Association*.

The NIH meeting provided information about what recent Women's Health Initiative study results mean for women who are taking hormone therapy and what

alternatives are available for specific conditions. For more information

about the meeting, go to <http://www4.od.nih.gov/orwh/workshop2002.html>. The FDA meeting will review the extent to which the WHI results might be extrapolated to other combination estrogen/progestin products and doses, the known benefits for approved indications in light of these new data, and the implications for future clinical trials of hormone therapy.

The hormone therapy recommendations and background evidence for clinicians are available on the AHRQ Web site at <http://www.ahrq.gov/clinic/3rduspstf/hrt/hrtrr.htm> as well as the *Annals of Internal Medicine* Web site at <http://www.acponline.org/journals/annals/hrt.htm>. Previous Task Force recommendations, summaries of the evidence, and related materials are available from the AHRQ Publications Clearinghouse. See the back cover of *Research Activities* for ordering information. Clinical information also is available from the National Guideline Clearinghouse™ at <http://www.guideline.gov>. ■

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Over two-thirds of survivors of early-stage cancer are still working 5 to 7 years later

Over two-thirds of workers were still employed 5 to 7 years after initial diagnosis of early-stage cancer, even though more than half required some time away from work while undergoing treatment. What's more, their employers were very supportive and accommodated reduced schedules and absenteeism during treatment, according to a pilot study.

We can be cautiously optimistic about the ability of people who have a history of cancer to continue to work, conclude Cathy J. Bradley, Ph.D., of Michigan State University, and Heather L. Bednarek, Ph.D., formerly a service fellow in the Center for Cost and Financing Studies, Agency for Healthcare Research and Quality, and now at St. Louis University in Missouri.

They surveyed by telephone 253 cancer patients (aged 35-75)

randomly selected from the Metropolitan Detroit Cancer Surveillance system 5 to 7 years after their diagnosis of early-stage breast, colon, lung, or prostate cancer, to assess the long-term employment effects of cancer. At the time of the interview, most patients were in their early 60s, except for prostate cancer patients who were in their mid-to-late 60s. Nearly all patients had received cancer treatment and had health insurance. Of those working at the time of their initial diagnosis, 67 percent were employed 5-7 years later. Many worked more than 40 hours a week and had relatively high earnings.

Most patients who stopped working did so because they retired (54 percent) or were in poor health or disabled (24 percent). Half of the retirees said that cancer did not factor into their decision to retire. Of those that had to reduce their

work schedules (55 percent) while undergoing cancer treatment, 86 percent returned to their former schedules. The cancer did limit the work of some patients, particularly those who needed to lift heavy loads or keep up with a pace set by other workers. To a lesser extent, cancer affected some survivors' ability to concentrate for long periods of time (12 percent), learn new things (14 percent), and analyze data (11 percent).

More details are in "Employment patterns of long-term cancer survivors," by Drs. Bradley and Bednarek, in *Psycho-Oncology* 11, pp. 188-198, 2002. Reprints (AHRQ Publication No. 02-R095) are available from AHRQ.** ■

Health Care Delivery

Doctors need to be attentive to the weight concerns of disabled adults, who are twice as likely as other adults to be obese

Adults with physical or sensory (sight or hearing) disabilities and those who have serious mental health problems are nearly twice as likely to be obese as other adults, and they usually want to lose weight, concludes a new study. Individuals who find it difficult to stand, walk, or climb stairs have the highest risk of becoming obese,

probably due to their limited ability to exercise.

Doctors should address the weight concerns and exercise opportunities of disabled patients to help them avoid obesity, suggest Christina Wee, M.D., M.P.H., and Lisa I. Iezzoni, M.D., M.Sc., of Beth Israel Deaconess

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Obesity in disabled adults

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Medical Center. In the study supported in part by the Agency for Healthcare Research and Quality (HS10223), the researchers used data from the 1994-1995 National Health Interview Survey of 145,007 community-dwelling people in the United States—25,626 of whom had one or more disabilities—to calculate the likelihood of being obese among adults with and without disabilities.

Among disabled adults surveyed, 25 percent were obese versus 15 percent of nondisabled adults. After adjusting for sociodemographic factors, disabled adults were twice

as likely as nondisabled adults to be obese. Individuals with lower extremity mobility difficulties were most likely to be obese, followed by those with limited vision and hearing problems. After further adjustment for coexisting medical problems, disabled adults were as likely as nondisabled adults to try to lose weight.

The exceptions were adults with severe lower extremity mobility difficulties, who were less likely to attempt weight loss, and adults with mental illness, whose psychotropic medications often caused them to gain weight, who were more likely to try to lose weight. Doctors were as likely to counsel disabled as nondisabled adults about weight loss, except for disabled adults with

severe lower extremity and upper extremity mobility difficulties, perhaps because they perceived greater impediments to their physical activity. More research is needed on the link between sensory disabilities and weight, concludes Dr. Iezzoni.

More details are in “Obesity among adults with disabling conditions,” by Evette Weil, B.A., Melissa Wachterman, B.A., Ellen P. McCarthy, Ph.D., M.P.H., and others, in the September 11, 2002 *Journal of the American Medical Association* 288(10), pp. 1265-1268. ■

Researchers examine nurse staffing and shortages

Many registered nurses (RNs) believe that low nurse staffing levels in acute care hospitals are jeopardizing the quality of patient care and prompting RNs to leave the profession. While 18 other States have considered legislation regarding nurse staffing in hospitals, in 1999 California became the first State to mandate minimum nurse-to-patient ratios in acute care hospitals, which will begin to be implemented by July 2003.

A study supported by the Agency for Healthcare Research and Quality (National Research Service Award training grant T32 HS00086) suggests that these mandatory nurse-to-patient ratios could generate opportunity costs

that are not easily measured and that may outweigh their benefits. A second AHRQ-supported study (HS09958) suggests that long overdue improvements in the hospital workplace and 40 percent increased enrollment in nurse education programs are needed to avoid the projected shortage of more than 400,000 RNs by the year 2020. The two studies are summarized here.

Coffman, J.M., Seago, J.A., and Spetz, J. (2002). “Minimum nurse-to-patient ratios in acute care hospitals in California.” *Health Affairs* 21(5), pp. 53-64.

The minimum nurse-to-patient ratios proposed by the California Department of Health Services (DHS) range from one nurse per

patient in operating rooms to one nurse per eight infants in newborn nurseries. DHS also proposes that minimum ratios for medical-surgical and rehabilitation units be phased in, moving from an initial one nurse (RN or licensed vocational nurse, LVN) per six patients to one nurse per five patients within 12 to 18 months of enactment. These proposed minimum ratios generally call for fewer patients per nurse than hospitals recommend and more patients per nurse than unions recommend.

Implementation of the initial ratios proposed by the California DHS would result in an increase of

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Note: Only items marked with a single (*) or double (**) asterisk are available from AHRQ. Items marked with a single asterisk (*) are available from AHRQ's clearinghouse. Items with a double asterisk (**) are also available through AHRQ InstantFAX. Three asterisks (***) indicate NTIS availability. See the back cover of *Research Activities* for ordering information. Consult a reference librarian for information on obtaining copies of articles not marked with an asterisk.

Nurse shortages

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\$143,836, or 1 percent on average, in expenditures for nursing wages per hospital per year (not including costs for employee benefits and employment taxes). Phasing in minimum nurse-to-patient ratios for medical-surgical and rehabilitation care units from 1:6 to 1:5 would result in an increase of \$217,210, or 1.7 percent per hospital per year. The estimated total annual cost of implementing the ratios at California's 400 acute care hospitals would be about \$87 million.

This approach may exact opportunity costs that could outweigh its benefits, assert the researchers. They point out that there are no data showing that mandatory minimum nursing ratios will improve patient outcomes. Also, hospitals may compensate for increased costs for nurses by cutting spending for housekeepers, ward clerks, and other support staff, since many of their tasks could be performed by RNs and LVNs. Such an approach could make hospital jobs even less attractive to nurses. Furthermore, higher personnel costs may compel hospitals to defer investments in medical technology and facilities that could improve the quality of care. The researchers suggest that a well-designed acuity-based ratio

system may be a more flexible alternative to minimum nurse-to-patient ratios.

Buerhaus, P.I., Needleman, J., Mattke, S., and Stewart, M. (2002, September). "Strengthening hospital nursing." *Health Affairs* 21(5), pp. 123-132.

Enrollment in nursing education programs, which has declined each year since 1995, would have to increase immediately by 40 percent to offset the projected shortage of more than 400,000 RNs by 2020. Long overdue improvements in the hospital workplace are also needed to recruit and retain registered nurses, according to these authors. They suggest that health policymakers focus on redesigning the work content and organization of hospital-based nursing care and improving the education of RNs, including support of nontraditional educational programs that enable licensed practical nurses, nurse aids, and others to become RNs.

For instance, hospital-based nursing care should be redesigned to reduce the inordinate amount of time RNs spend in functions other than providing patient care. Excessive paperwork, inefficient communication systems, outdated patterns of care delivery, and other difficulties contribute to low job satisfaction and a frustrating work environment. They are also major barriers to providing efficient and

appropriate nursing care. Efforts also are needed to improve the relationship between the nursing profession and hospitals. AHRQ and other agencies and organizations should continue to fund redesign efforts and knowledge about best care practices.

The education of RNs must also be improved to better prepare for the future. For example, only 23 percent of baccalaureate nursing education programs have a required course in geriatric nursing, despite the rapidly aging population. Also, nursing schools need to offer more courses in clinical management, so that RNs are better able to delegate nursing functions to others and oversee the larger non-RN workforce. Policymakers should develop programs that offer financial support for continuing education and formal course work designed to help RNs more capably use technology and computer information systems and apply quality improvement methods to clinical and administrative processes. Finally, the quality of care associated with nurse staffing should be monitored. ■

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Evidence is sparse on the use of epinephrine-containing anesthetics in hypertensive dental patients

One-fourth of the U.S. population suffers from hypertension, and many hypertensive adults are seen in a typical dental practice. Most recommendations caution dentists about use of local anesthetics with epinephrine, which increases blood pressure, in hypertensive patients. Some caution against epinephrine use in controlled hypertensive patients taking antihypertensive medications with known epinephrine interactions. Others consider epinephrine use to be acceptable with appropriate precautions and monitoring. However, evidence is insufficient to gauge the actual risk that epinephrine-containing anesthetics pose for hypertensive dental patients, concludes a study supported by the Agency for Healthcare Research and Quality (contract 290-97-0011).

A systematic review of 406 studies on the topic by researchers at the RTI International - University of North Carolina Evidence-based Practice Center yielded six studies (a total of 325 patients, 177 hypertensive) that met inclusion criteria. These studies revealed low risk of elevated high blood pressure and related problems (for example, cerebral hemorrhage and acute heart failure) and minimal reporting of adverse events among hypertensive dental patients receiving epinephrine-containing anesthetics. The

studies did not address effects of epinephrine-impregnated gingival retraction cords on hypertensive patients.

Unfortunately, the strength of the evidence is poor, with few studies and poor quality studies, note the researchers. The five studies of patients with uncontrolled (unmedicated) hypertension only assessed changes in blood pressure and heart rate as risk indicators (but not stroke volume, for example). Only one study noted patient-reported side effects. The studies varied on when they collected epinephrine exposure readings, and only one of the six studies examined controlled hypertensive patients.

See "A systematic review of cardiovascular effects of epinephrine on hypertensive dental patients," by James D. Bader, D.D.S., M.P.H., Arthur J. Bonito, Ph.D., and Daniel A. Shugars, D.D.S., Ph.D., in the June 2002 *Oral Surgery Oral Medicine Oral Pathology* 93, pp. 647-653.

Editor's note: Copies of the AHRQ evidence report on this topic, *Cardiovascular Effects of Epinephrine on Hypertensive Dental Patients* (AHRQ Publication No. 02-E006), and a summary of the report (AHRQ Publication No. 02-E005) are available from AHRQ.* See the back cover of *Research Activities* for ordering information. ■

Minority Health

State outreach efforts are needed to enroll more non-English-speaking families in Medicaid programs

Greater outreach efforts, including simpler application forms and more opportunities for direct application assistance, are needed to enroll more poor families who don't speak English at home in State Medicaid health insurance programs, according to a study that was supported in part by the Agency for Healthcare Research and Quality (HS10207). These

limited English proficiency (LEP) families, who account for one-third of the Medicaid-eligible children in this study, were much more likely than English-proficient families to learn about the Massachusetts Medicaid program from medical providers, to receive assistance with enrollment (65 vs. 33 percent), and to receive this help from staff at medical sites (as well as family and friends) instead of

from the State's toll-free telephone information line.

LEP families also were more likely than English-proficient families to identify barriers to Medicaid enrollment related to "know-how," that is, knowing about the Medicaid program; finding out if their child was eligible; and getting information about how to

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Medicaid programs

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enroll. The three most frequently cited individual barriers to enrollment were not knowing if a child was eligible for coverage under Medicaid (63 percent), the belief that Medicaid was only for people on welfare (33 percent), and not knowing how to sign up (31 percent).

Two enrollment procedures particularly difficult for LEP families were completing the application process without assistance and providing written

documentation to complete a partially filled-out application. These differences were based on language proficiency and persisted after controlling for marital status, family composition, place of residence, length of enrollment, and employment status.

These findings were based on a telephone survey of 1,055 parents of Medicaid-eligible (but unenrolled) children in Massachusetts. Emily Feinberg, Sc.D., of the Harvard School of Public Health, and colleagues asked parents how they learned about the Medicaid program, how

they enrolled their children, and their perceived barriers to enrollment. The researchers evaluated the independent effect of language on enrollment after controlling for demographic characteristics.

See “Language proficiency and the enrollment of Medicaid-eligible children in publicly funded health insurance programs,” by Dr. Feinberg, Katherine Swartz, Ph.D., Alan M. Zaslavsky, Ph.D., and others, in the March 2002 *Maternal and Child Health Journal* 6(1), pp. 5-18. ■

HIV/AIDS Research

Nearly 20 percent of work discrimination charges filed in the 1990s by people with HIV disease had merit

People infected with the human immunodeficiency virus (HIV) are considered to be especially vulnerable to workplace discrimination because of the stigma associated with their disease, unfounded fears about HIV transmission, and the association of HIV infection with homosexuality and injection drug use. The Americans with Disabilities Act (ADA), enacted by Congress in 1990, provides people living with HIV disease with legal means of redress against discrimination.

David M. Studdert, Sc.D., of the Harvard School of Public Health, measured for the first time the extent to which people with HIV disease actually make use of the protections available to them under the ADA. He found that of the 3,520 HIV discrimination charges filed through 1999, 18 percent had merit, and 14 percent resulted in monetary compensation.

In a recent study, which was supported in part by the Agency for Healthcare Research and Quality (K02 HS11285), Dr. Studdert analyzed all charges under the ADA filed with the Equal Employment Opportunity Commission between 1992 and 1999 alleging HIV discrimination in the workplace. He examined respondent employers, issues in dispute, and outcomes of charges. He then compared the characteristics of

workers who brought charges with a nationally representative sample of workers with HIV disease (from the HIV Cost and Services Utilization Study).

HIV-infected workers who were female, less than 25 years of age, and aged 25-34 years filed disproportionately fewer charges than other workers with HIV disease. Either there is less actual or perceived discrimination among these workers, or they have less inclination to seek relief when discrimination occurs.

Employers in the retail industry, especially in food stores, were the most frequent target of charges. Seven States accounted for 55 percent of all charges, and three States accounted for one-third. Nearly 60 percent of all charges alleged discriminatory discharge from employment, 19 percent alleged discrimination in terms or conditions of employment, 13 percent alleged harassment, and 11 percent alleged failure to provide a reasonable accommodation such as reduced hours or a less demanding job.

More details are in “Charges of human immunodeficiency virus discrimination in the workplace: The Americans with Disabilities Act in action,” by Dr. Studdert, in the *American Journal of Epidemiology* 156(3), pp. 219-229, 2002. ■

Practice sites and medical groups may be more meaningful sources for measuring health care quality than health plans

Many national efforts to assess health care quality have focused on health plans as the chief measure. The Consumer Assessment of Health Plans Study (CAHPS®) survey, which was developed by the Agency for Healthcare Research and Quality, is the most widely used health care survey in the United States. However, medical groups and doctors' offices hire and fire physicians, shape and reinforce practice culture, and determine the pace and flow of patient visits. In fact, a new study using the recently developed "group CAHPS" (G-CAHPS®) survey found that practice sites and medical groups explained substantial amounts of the variation in patient assessments of care within health plans.

Practice sites and medical groups may explain more of the variation in certain measures of health care quality than health

plans, according to Paul D. Cleary, Ph.D., of Harvard Medical School. Dr. Cleary and his colleagues evaluated variations in G-CAHPS scores among a sample of adult patients who received care in 1999 through three managed care contracts of Partners Community Healthcare, Inc., which included 28 medical groups that provided care at 49 practice sites (doctor's office or clinic). Their study was supported in part by AHRQ (HS09205). The G-CAHPS contains 100 questions, 50 of which pertain to patient experiences with their medical group, 5 pertain to global evaluation of care, and others relate to patient demographics, health status, and use of services.

Practice sites accounted for at least 60 percent of the explainable variation for eight out of the nine measures of care for which there were significant between-site differences and the largest share of

explainable variation for three of the four global rating items. Groups accounted for the second largest share of variability for most measures (accounting for 30 percent of the variance for access to and timeliness of care), but these effects were modest relative to site-level effects. Regional service organizations (RSOs), which included one or more medical groups such as physician/hospital organizations, did not explain a significant amount of variability in responses, and health plans accounted for even less variation.

More details are in "Variation in patient-reported quality among health care organizations," by Loel S. Solomon, Ph.D., Alan M. Zaslavsky, Ph.D., Bruce R. Landon, M.D., M.B.A., and Dr. Cleary, in the Summer 2002 *Health Care Financing Review* 23(4), pp. 85-98. ■

Health Care Costs and Financing

HMO growth during the 1990s was associated with less physician income growth, practice autonomy, and satisfaction

Before managed care, patients' interest in receiving as much care as possible and physicians' financial interests were closely aligned. With the advent of managed care, a variety of administrative mechanisms (for example, utilization review and physician profiling) and financial incentives (for example, capitation, bonuses, and reduced fees) were instituted that were designed to limit the amount of care provided. Continuing growth in the proportion of the population enrolled in health maintenance organizations (HMOs) and financial incentives to reduce services during the 1990s were

significantly related to lower physician income growth, reduced practice autonomy, and decreased satisfaction (primarily due to the former two), finds a new study.

With support from the Agency for Healthcare Research and Quality (HS09196), Jack Hadley, Ph.D., of the Urban Institute, and Jean M. Mitchell, Ph.D., of Georgetown University, used 1991 and 1997 interview data from nearly 1,500 doctors practicing in 75 large U.S. metropolitan areas to examine the relationship between HMO growth and physicians' perceived

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HMO growth

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financial incentives and physicians' income, practice autonomy, and satisfaction. Mean net income from medical practice, which was \$146,575 in 1990, increased by just over \$56,000 between 1990 and 1996. Physicians who in 1997 reported an overall financial incentive in their practice to reduce services saw their incomes grow by \$16,626 less than other physicians' incomes.

Physicians felt that these financial incentives reduced their freedom to care for patients who required heavy resource use, shortened time spent with

patients, and hampered their ability to care for people who were unable to pay. About 44 percent of doctors surveyed reported some decrease in autonomy, and between 30 and 36 percent reported decreased satisfaction in 1997 compared with 1991. Both increased HMO penetration and having a perceived financial incentive to reduce services negatively affected current practice and career satisfaction.

See "The growth of managed care and changes in physicians' incomes, autonomy, and satisfaction, 1991-1997," by Drs. Hadley and Mitchell, in the *International Journal of Health Care Finance and Economics* 2, pp. 37-50, 2002. ■

Federal Employees Health Benefit Program uses a capped premium subsidy to help reduce adverse selection

In the Federal Employees Health Benefit Program (FEHBP), workers can choose from among a wide variety of national health insurance plans that have fixed premiums across metropolitan statistical areas (MSAs) and qualifying local plans, whose premiums more closely reflect conditions in each MSA. Insurers who are part of the FEHBP are prevented from charging individually risk-rated premiums. Instead, the Federal Government contributes a fixed 75 percent of premiums up to a capped amount that is set below the national plan premiums. This capped premium subsidy in FEHBP helps reduce adverse selection, whereby consumers at low risk of health problems select suboptimal plans to avoid

subsidizing high-risk consumers who increase health care costs.

Adverse selection can result in premium spirals that eliminate more generous plans as viable alternatives, but the design of the FEHBP may help to avoid such outcomes, explain Bradley M. Gray, Ph.D., of the University of Illinois at Chicago, and Thomas M. Selden, Ph.D., of the Center for Cost and Financing Studies, Agency for Healthcare Research and Quality. They used FEHBP data on individual (not family) coverage for nonelderly, nonunionized enrollees and variation in the premium subsidy cap across MSAs (due to variation in local price differences) to analyze the impact of the capped premium subsidy on adverse selection.

In all cases, the fixed-effects results showed that within-MSA differences in enrollee age (one indicator of health risk) were significantly correlated with differences in the premiums that enrollees selected, evidence consistent with the presence of risk-based selection across plans. The age-premium gradient was not large, only changing about 9 percent between ages 25 and 64, but it largely disappeared as the subsidy cap increased.

More details are in "Adverse selection and the capped premium subsidy in the Federal Employees Health Benefits Program," by Drs. Gray and Selden, in the *Journal of Risk and Insurance* 69(2), pp. 209-224, 2002. Reprints (AHRQ Publication No. 02-R090) are available from AHRQ.** ■

New AHRQ initiative will move research into practice more quickly

The Agency for Healthcare Research and Quality has announced funding of a coordinated set of 22 projects called Partnerships for Quality. The projects will develop partnerships among researchers, health plans, medical and nursing facilities and services, employers, consumer groups, and professional societies, including the American Medical Association and the Leapfrog Group, to test prototype activities aimed at accelerating the health system's adoption of research findings that have been shown to improve quality of care for patients.

The projects will test financial incentives and rewards to speed the adoption of recommended hospital patient safety practices; test an innovative team-oriented, practice-based continuing medical education program to improve care for patients with type 2 diabetes; build partnerships to promote

cooperation in implementing quality improvement strategies in long-term care facilities; incorporate validated quality measures into the recertification of family physicians; and test other approaches to implementing tools and research findings into everyday health care.

The projects span much of the Nation and involve more than 88,000 medical providers, 5,800 hospitals, nursing homes and other health care facilities, and 180 health plans. Funding for fiscal year 2003 activities totals \$2.4 million.

The new initiative is part of AHRQ's overall strategy to have research findings result in real improvements in the quality and outcomes of health care. The partners were selected from among applicants to AHRQ's Partnerships for Quality research solicitation published last May.

Other projects in the Partnerships for Quality initiative include those that will help community-based primary care practices adopt quality improvement models for treating heart disease, stroke, diabetes, and other conditions; create a national center for value-based purchasing methods; and test a bioterrorism simulation model with large health care networks.

For a list of the awards, including the organizations/institutions and principal investigators, go to <http://www.ahrq.gov/news/press/pr2002/poqtable.htm>. For more information about individual awards, go to the AHRQ Grants Online Database at <http://www.gold.ahrq.gov> and search by the principal investigator's name. ■

AHRQ awards new grants to primary care practice-based research networks

The Agency for Healthcare Research and Quality has awarded developmental grants to 36 primary care practice-based research networks as part of an ongoing initiative. The awards total more than \$3 million in the first year, with a combined 3-year total of more than \$6 million. Primary care practice-based research networks are groups of primary care practices working together with academic researchers to answer community-based health care questions and to translate research findings into practice.

Many of the awards to newly formed networks will support the development of an information technology infrastructure to facilitate research and implementation of findings. Some of the awards will fund pilot research projects on such topics as optimal management of chronic diseases, the delivery of preventive services, community-based detection and

response to emerging public health threats, and disparities in the health care of priority populations.

A listing of individual networks, principal investigators, and institutional sponsors receiving awards is available at <http://www.ahrq.gov/research/pbrnproj.htm>. Although headquartered in 25 States, the networks receiving grants include primary care practices located in all 50 States and the District of Columbia, many serving minority and low-income patients as well as residents of underserved rural and urban areas.

The Agency also has recently awarded a contract to Indiana University at Indianapolis, in partnership with the Chicago-based National Opinion Research Center, for the establishment of a Primary Care Practice-Based

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Research Network Resource Center. The center will assess the developmental needs of individual networks and provide appropriate technical and consultative services. The center will support not only the 36 Agency-funded networks but also those networks to be awarded grants as part of an upcoming initiative cosponsored by AHRQ and the Robert Wood Johnson Foundation. This multimillion-dollar initiative will fund the study of the networks' efforts to promote healthy behaviors among patients seen in primary care practices.

A list of the newly awarded grants—including the institution/organization, location, and first year award—follows:

- University of Alabama, Birmingham; \$150,000
- University of Arkansas, Little Rock; \$49,059
- Community Health Center Network, Oakland, CA; \$50,000
- University of California, Los Angeles; \$49,997
- University of California, San Francisco; \$100,000
- University of Southern California, Los Angeles; \$49,788
- University of Colorado, Denver; \$99,950
- Connecticut Primary Care Association, Hartford; \$50,000
- Yale University, New Haven, CT; \$50,000
- Georgetown University, Washington, DC; \$50,000
- Medical College of Georgia, Augusta; \$49,628
- American Academy of Pediatrics, Elk Grove Village, IL; \$149,997
- University of Iowa, Iowa City; \$149,486
- American Academy of Family Physicians, Leawood, KS; \$149,811
- University of Kentucky, Lexington; \$50,000
- Louisiana State University, Baton Rouge; \$47,777
- Cambridge Medical Care Foundation, Cambridge, MA; \$50,000
- Wayne State University, Detroit, MI; \$49,916
- University of Minnesota, Minneapolis; \$149,053
- Washington University, St. Louis, MO; \$50,000
- University of New Mexico, Albuquerque; \$148,239
- Duke University, Durham, NC; \$147,637
- University of North Carolina, Chapel Hill; \$149,982
- Case Western Reserve University, Cleveland, OH; \$50,000
- Cincinnati Children's Hospital, Cincinnati, OH; \$50,000
- University of Oklahoma, Oklahoma City; \$149,473
- Oregon Health & Science University, Portland; \$49,810
- American College of Physicians, Philadelphia, PA; \$149,800
- Children's Hospital, Philadelphia, PA; \$50,000
- Children's Hospital, Pittsburgh, PA; \$150,000
- Crozer-Chester Medical Center, Springfield, PA; \$149,060
- Baylor College of Medicine, Houston, TX; \$100,000
- Scott and White Memorial Hospital, Temple, TX; \$49,920
- Ambulatory Pediatric Association, McLean, VA; \$50,000
- University of Wisconsin, Milwaukee; \$50,000
- University of Wisconsin, Madison; \$48,104

Go to <http://www.ahrq.gov/research/pbrnfact.htm> for more information about the research networks. ■

AHRQ has funded nearly 100 research projects focused on improving patient safety

In fiscal year 2002, Congress designated \$50 million of the Agency for Healthcare Research and Quality's \$270 million budget for patient safety research initiatives, making AHRQ the world's largest supporter of patient safety research. To date

AHRQ has funded 94 projects to increase the Nation's capacity to conduct patient safety research, according to Gregg S. Meyer, M.D., M.Sc., formerly the director of AHRQ's Center for Quality Improvement and Patient Safety,

and former AHRQ researcher Christina Rall.

AHRQ-funded research initiatives range from evaluations of State-wide patient safety reporting systems to informatics-based interventions in small clinics.

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Patient safety research

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The research settings are diverse, including hospitals, clinics and physicians' offices, acute care facilities, nursing homes and other long-term care facilities, home care programs, and hospice care.

AHRQ grantees and other experts recently gathered at the conference, "Making the Health Care System Safer," which was designed to facilitate collaboration among researchers and others in the field and implementation of patient safety initiatives in patient care settings. A coordinating center serves as a central information

source for investigators as well as a forum for communication that can multiply the success of individual initiatives. In addition, AHRQ's Stanford-University of California-San Francisco Evidence-based Practice Center's recent review of the literature on safety practices resulted in the report, *Making Health Care Safer*.

AHRQ's future safety-related products, which will begin to be available in early 2003, include the first *National Healthcare Quality Report*, mandated by Congress in the Agency's reauthorization legislation; the "Web M&M," a national Web-based repository of

information on medical errors; a new tool for assessing the safety culture of health care organizations; and an Institute of Medicine project on data standardization. The Agency will continue to nurture partnerships to enhance patient safety with other government agencies and private-sector entities.

See "Use of evidence-based data to drive your patient safety program," by Drs. Meyer and Rall, in the August 2002 *American Journal of Infection Control* 30, pp. 314-317. Reprints (AHRQ Publication No. 02-R096) are available from AHRQ.** ■

Announcements

Cultural competence guides now available to aid managed care plans

Contractors from the Agency for Healthcare Research and Quality's Integrated Delivery System Research Network have developed two guides to help managed care plans implement cultural competence interventions. The guides were commissioned by the Centers for Medicare & Medicaid Services (CMS).

Designed by AHRQ, the Integrated Delivery System Research Network is a model of field-based research that links the Nation's top researchers with some of the largest health care systems to conduct fast-track research on cutting-edge topics in health care.

Each year, CMS identifies a topic for a national quality assessment and performance improvement project for Medicare+Choice organizations. In 2003, these organizations have a choice of conducting a QI project that addresses either clinical health care disparities or the provision of cultural and linguistically appropriate services. The following two guides have been developed to assist those organizations that choose to address cultural and linguistically appropriate services.

- *Providing Oral Linguistic Services: A Guide for Managed Care Plans*. This guide outlines six steps for developing an oral linguistic services plan: identify oral linguistic needs of membership; assess the capabilities of the managed care plan; identify points of contact for members of the plan; consider different strategies; assemble a plan; and monitor oral linguistic services strategies.
- *Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans*. This guide is intended to assist plans in assessing the diversity of their population and their current level of cultural and linguistic competence; identifying feasible priority areas for improvement of cultural and linguistically appropriate services based on the assessment; and developing a plan to implement cost-effective, manageable interventions to address these priority areas.

Both guides are available for review and download from the CMS Web site. Go to www.cms.gov/healthplans/quality/project03.asp to access the guides. ■

AHRQ to host annual child health services research meeting

The Agency for Healthcare Research and Quality will cosponsor the Fifth Annual Child Health Services Research (CHSR) meeting to be held Thursday, June 26, 2003, at the Opryland Hotel in Nashville, TN. For more information, visit <http://www.academyhealth.org/childhealth> or call 202-292-6700. Or, you may send an e-mail to childhealth@academyhealth.org.

For the second time, we are issuing a call for panels for the

CHSR meeting. The meeting offers researchers the opportunity to disseminate their findings and provide policymakers and clinicians with the information they need to make sound decisions to improve our Nation's health.

Researchers are encouraged to collaborate with colleagues and submit an organized program of findings from child health services research for a full 90-minute session. The lead organizer should submit a proposal that includes a

brief overview of the panel and individual abstracts from the presenters.

Please visit <http://www.ahrq.gov/child/chsrcall.htm> for priority topic areas and instructions. Applications must be submitted by e-mail (only) to chsr2003@ahrq.gov and must be received by January 15, 2003. We encourage you to submit your application early! ■

New MEPS data files are released

The Agency for Healthcare Research and Quality has released new public use data files from the Agency's Medical Expenditure Panel Survey (MEPS). MEPS is the third in a series of nationally representative surveys of medical care use and expenditures sponsored by AHRQ. MEPS is cosponsored by the National Center for Health Statistics. The first survey, the National Medical Care Expenditure Survey (NMCES) was conducted in 1977, and the second survey, the National Medical Expenditure Survey (NMES), was carried out in 1987. MEPS began in 1996 and is ongoing.

MEPS collects detailed information on health care use and expenses, sources of payment, and insurance coverage of individuals and families in the United States. MEPS comprises four component surveys: the Household Component, the Medical Provider Component, the Insurance Component, and the Nursing Home Component.

The following MEPS public use data files were released October 2002 and are now available online.

- **MEPS HC-038: 1999 Full-Year Consolidated Data File.** Released as an ASCII file (with related SAS programming statements) and an SAS transport dataset, this file provides information collected on a nationally representative sample of the civilian noninstitutionalized U.S. population for calendar year 1999. The file consists of MEPS survey data obtained in rounds 2, 3, 4, and 5 of Panel 3 and rounds 1, 2, and 3 of Panel 4 (i.e., the rounds for the MEPS panels covering calendar year 1999) and consolidates all of the final 1999

person-level variables onto one file. This file contains the following variables previously released on HC-031: survey administration, demographics, employment, health status, and health insurance. The HC-038 file also includes these variables: parent identifiers, access to care and disability days variables, language of interview variable, income variables, use and expenditure variables, and summary yearly health insurance variables. The 1999 consolidated data file is available on the MEPS Web site at <http://www.meps.ahrq.gov/Puf/PufDetail.asp?ID=93>.

- **MEPS HC-037: 1999 Medical Conditions File.** This public use data file provides information on household-reported medical conditions collected on a nationally representative sample of the civilian noninstitutionalized population of the United States for the 1999 MEPS Household Component. It provides information reported in the 1999 portion of round 3 and rounds 4 and 5 for Panel 3, as well as rounds 1 and 2 and the 1999 portion of round 3 for Panel 4 (i.e., rounds for MEPS panels covering calendar year 1999). The 1999 Medical Conditions File is available on the MEPS Web site at <http://www.meps.ahrq.gov/Puf/PufDetail.asp?ID=94>.
- **MEPS HC-033I: Appendix to MEPS 1999 Event Files.** MEPS HC-033I contains two data files: File 1 is used for linking the MEPS 1999 Medical Condition File (HC-037) with the MEPS

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New MEPS data files

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1999 event files (HC-033A through HC-033H); File 2 is used for linking the MEPS 1999 Prescribed Medicines Event File (HC-033A) with other 1999 event files. This release also includes two tables provided as PDF files: Table 1, the "MEPS 1999 Condition-Event Frequency" table contains unweighted and weighted counts of records on the MEPS 1999 event files for each of the conditions,

procedures, and clinical classification codes on the MEPS 1999 condition file; Table 2, the "MEPS 1999 Utilization and Expenditures Summary" table contains statistics for all of the utilization and expenditure variables contained on the MEPS 1999 person-level and event-level files. The Appendix to the MEPS 1999 Event Files is available on the MEPS Web site at <http://www.meps.ahrq.gov/Puf/PufDetail.asp?ID=95>. ■

Calling all AHRQ researchers! Help Us to Help You

We would like to do a better job of promoting and marketing your research. Over the past several years, AHRQ has succeeded in improving communications with grantees and contractors. However, at the present time we only have advance notification of an estimated 37 percent of journal articles stemming from AHRQ-funded research. Obviously, there is much more that can be done.

You can help us in this effort by notifying us once your article has been accepted for publication. When you are notified by a journal that your article will be published, please send a copy of the manuscript, along with the journal name, anticipated publication date, and contact information, to your AHRQ project officer. Also, please notify us of your article's acceptance by sending an e-mail to journalpublishing@ahrq.gov.

Your manuscript will be reviewed for potential AHRQ marketing efforts. Please be assured that AHRQ always honors journal embargo, and we do not release any details about your publication outside of the agency prior to publication. ■

Grant final reports now available from NTIS

The following grant final reports are now available for purchase from the National Technical Information Service (NTIS). Each listing identifies the project's principal investigator (PI), his or her affiliation, grant number, and project period and provides a brief description of the project. See the back cover of *Research Activities* for ordering information.***

Editor's note: In addition to these final reports, you can access information about these projects from several other sources. Most of these researchers have published interim findings in the professional literature, and many have been summarized in *Research Activities* during the course of the project.

To find information presented in back issues (1995-2002) of *Research Activities*, go the AHRQ

Web site at www.ahrq.gov and click on "Research Activities: Online Newsletter" and then "Search Research Activities." To search for information, enter either the grant/contract number or principal investigator's name in the query line. A reference librarian can help you find related journal articles through the National Library of Medicine's Pub Med.

Adoption of Cancer Pain Guidelines in Managed Care.
Mildred Z. Solomon, Ed.D.,
Education Development Center,
Inc., Newton, MA. AHRQ grant
HS08691, project period 6/1/96-
11/30/01.

The grantee evaluated a voluntary, two-tiered dissemination strategy designed to reduce pain among cancer patients by improving primary care nurses' and

physicians' use of the AHRQ cancer pain guideline. Four treatment clinics received an intervention that encouraged caregivers to adopt routine procedures for pain screening, assessment, followup, and documentation and provided nurses and physicians with education to improve opioid knowledge and confidence in prescribing opioids. Evaluation data were drawn from 1,733 interviews with 791 patients, clinician surveys, and prescription records. Treatment clinic clinicians prescribed more opioids than those in control clinics and demonstrated increased knowledge about prescribing opioids. However, patients in the treatment clinics did not report better pain outcomes than patients in control clinics.

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Although the 6-hour, skills-based educational program achieved improvements in clinician knowledge and prescribing behavior, the recommended routine assessment and documentation procedures were not adopted by clinicians. This probably accounts for the lack of impact on patient outcomes and suggests that voluntary adoption of new procedures is insufficient to improve patient outcomes. Institutional mandates may be needed to achieve substantial improvement in pain-related outcomes. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108747; 102 pp, \$33.00 paper, \$17.00 microfiche)***

***Adult Global Quality Assessment Tool.* Elizabeth McGlynn, M.P.P., Ph.D., RAND, Santa Monica, CA. AHRQ grant HS09463, project period 9/30/96-9/29/01.**

Recognizing the limits of existing methods for evaluating quality, these researchers developed a more comprehensive, clinically detailed system of quality assessment for adults known as the Quality Assessment Tools system, or QA Tools. They selected 25 chronic and acute conditions common to adults, reviewed the literature, developed draft indicators, selected three expert panels (nine members each) to refine and finalize the indicators using a modified Delphi method, developed medical record abstraction software to facilitate data collection, applied the method in two health plans, and analyzed the data. Data analysis continues, and only preliminary findings appear in this final report. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108736; 90 pp, \$29.50 paper, \$12.00 microfiche)***

***Application of the AHCPR Urinary Incontinence Guideline in Nursing Homes.* Nancy M. Watson, M.S., Ph.D., University of Rochester, Rochester, NY. AHRQ grant HS08491, project period 6/1/96-5/31/01.**

These researchers assessed the extent to which the 1996 AHCPR clinical practice guideline on urinary incontinence (UI) was familiar, understood, and used in nursing homes and factors related to that process. The project involved 52 nursing homes (7,458 beds) in upstate New York. The evaluation/treatment of new cases of UI including new admissions with UI (n=201) was assessed using record review and interviews of nursing assistants. Need for UI evaluation/treatment occurred at a rate of 4.3 cases per 100 beds per 12 weeks. Overall, 31 percent of the most important guideline standards were met (0 to 65 percent) considering only those standards appropriate for each individual case. Areas of concern were medical providers' awareness of new UI, attention to reversible causes, rectal/prostate examinations, and post-void residual testing. Barriers to guideline use included lack of knowledge and resources. Awareness of and familiarity with the guideline were low. Current research is underway to see if cost savings and improved UI outcomes are possible using a focused approach by nurse practitioners to implement the guideline in nursing homes. (Abstract, executive summary, and final report, NTIS accession no. PB2001-109052; 102 pp, \$33.00 paper, \$12.00 microfiche)***

***Building Bridges VII. Assessing Policy Decisions and Their Impact on Health Care Delivery.* Barbara Lardy, M.P.H., American Association of Health Plans, Washington, DC. AHRQ grant**

HS10946, project period 3/1/01-2/28/02.

This conference was held in Seattle, WA, April 26-27, 2001, and was sponsored by the American Association of Health Plans, AHRQ, the Centers for Disease Control and Prevention (CDC), and the Blue Cross and Blue Shield Association. The conference focused on current research activities, results, and application of findings by health plans, purchasers, and the research community; how health care policymakers use research to generate quality improvements; translation of research findings into policies that improve health care delivery; and the impact of policy decisions on clinical practice and medical management. (Abstract, executive summary, and final report, NTIS accession no. PB2003-100058; 84 pp, \$29.50 paper, \$12.00 microfiche)***

***Defining Risks for Chronic Disease in Spinal Cord Injury.* Sin Wang, Ph.D., University of Illinois, Chicago. AHRQ grant HS11277, project period 9/30/00-9/29/01.**

Previous studies have shown increased risks for various chronic diseases in spinal cord injured individuals (SCIs). The purpose of this investigation was to assess the prevalence in SCIs of type 2 diabetes, hypertension, obesity, and dyslipidemia and their associated risk factors using sampling techniques that would allow findings to be generalizable to other similar populations. This survey was conducted in a university outpatient center and involved 115 adult men with paraplegia who were recruited from active medical records at a large urban SCI hospital using systematic sampling techniques based on time since injury. The main outcome measures were body mass index (BMI), waist circumference (WC), blood

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pressure, serum glucose, total and LDL cholesterol, and triglyceride (TG) concentrations. Prevalence rates for diabetes, hypertension, lower HDL-cholesterol, elevated TG concentrations, underweight, and large WC were higher, while obesity and elevated TC concentrations were lower in this population than for similar able-bodied U.S. males. Large WC significantly increased risk for diabetes. This population has increased prevalence rates for the cluster of risk factors that characterize the metabolic syndrome that may explain the exaggerated prevalence of type 2 diabetes, hypertension, and cardiac disease. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108743; 106 pp, \$33.00 paper, \$17.00 microfiche)***

***Does Cost-Effectiveness Make a Difference? Lessons from Pap Smears.* Michael Hagen, M.D., University of Kentucky, Lexington. AHRQ grant HS10931, project period 9/15/00-9/14/01.**

Participants at the 2000 meeting of the Society for Medical Decision Making explored the public policy implications of cost-effectiveness analyses and the challenges encountered when moving research results into the policy arena. Presentations focused on cost-effectiveness analysis and practice policy, cost-effectiveness in the real world of cancer screening, the role of evidence in cost-effectiveness analysis, and the role of cost-effectiveness in a managed care organization. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108739; 18 pp, \$23.00 paper, \$12.00 microfiche)***

***Emergency Department Data Conference Phase 1. Agenda-Setting Meeting.* Denise Love,**

National Association of Health Data Organizations, Salt Lake City, UT. AHRQ grant HS10944, project period 2/1/01-1/31/02.

This meeting was convened in March 2001 to address how States can overcome the technical and political barriers associated with emergency department database development and use. During the agenda-setting meeting, an advisory committee was established, background materials were assembled, topics were prioritized, and speakers were identified for the upcoming conference. (Abstract, executive summary, and conference agenda, NTIS accession no. PB2002-108740; 56 pp, \$27.00 paper, \$12.00 microfiche)***

***High-Risk Periods for Child Injury Among Siblings.* David Grossman, M.D., M.P.H., University of Washington, Seattle. AHRQ grant HS10724, project period 3/1/00-2/28/02.**

The goal of this project was to examine patterns of injury risk within sibling groups in order to determine whether a clinical encounter for injury care could be used as a marker to identify siblings at high risk for subsequent injury. The project involved 16,335 children, aged 0-15 who were enrolled in an HMO between 1995 and 1997; this population contributed 38,215 child-years of data. The researchers tracked medically treated injuries that had been diagnosed and classified as unintentional. Incidence rates and hazard ratios were calculated for children whose siblings had been injured in the previous 180 days, compared with children without such exposure, adjusted for age, sex, sibling group size, and non-injury health care use. A total of nearly 9,000 injuries were sustained by 5,851 children. Injury incidence was 319 per 1,000 child-years among children with recent sibling injury and 235 per 1,000 child years

among children without this exposure. When minor injuries were excluded, the adjusted RR was 1.95. This study showed that injury risk is shared within sibling groups and varies according to recent sibling injury experience. Clinical encounters for injury care might be used to identify sibling groups at increased risk of injury. (Abstract, executive summary, and final report; NTIS accession no. PB2002-108737; 36 pp, \$25.50 paper, \$12.00 microfiche)***

***HIV Cost and Services Utilization Study (HCSUS).* Martin Shapiro, M.D., Ph.D., RAND, Santa Monica, CA. AHRQ grant HS08578, project period 9/1/94-10/31/00.**

HCSUS was the first national probability sample study of people with a single chronic disease. HCSUS demonstrated that most people with HIV disease are not in regular care, and that racial/ethnic and socioeconomic disparities exist in access to care including access to HIV treatment. Case management improves care, but there is considerable unmet need for social services. Patients' physical and mental health status are impaired with HIV disease, and psychiatric disorders are very common among patients with HIV. Overall costs declined with the introduction of protease inhibitor medicines. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108744; 100 pp, \$29.50 paper, \$17.00 microfiche)***

***Impact of Clinical Pathways for Rehabilitation Care.* Deborah Dobrez, Ph.D., Northwestern University, Evanston, IL. AHRQ grant HS10375, project period 9/30/99-9/20/01.**

Implementation of the prospective payment system (PPS) for post-acute rehabilitative care is

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likely to disrupt the medical rehabilitation industry, prompting institutional responses to improve efficiencies and control costs. Clinical pathway protocols could play a key role in increasing care efficiency. This study models the impact of therapy on cost and discharge function for stroke patients at a large academic acute rehabilitation hospital. The researchers estimated hypothetical PPS reimbursements and simulated the effects of institutional strategies to improve efficiency on costs and discharge function. Estimated PPS reimbursements were \$10,825 less per patient on average than estimated costs (41 percent lower). The concern with cost pressure affecting treatment decisions is that patient outcomes will suffer as a result. These simulations suggest that under some scenarios there may be small changes in discharge functional status. Under other scenarios, however, cost-saving measures need not harm patient outcomes. For example, substitution from individual to group therapy was predicted to improve motor and cognitive function while reducing cost by nearly one-third on average. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108016; 20 pp, \$23.00 paper, \$12.00 microfiche)***

Northwest Health Policy Research Conference. Aaron Katz, M.D., University of Washington, Seattle. AHRQ grant HS09817, project period 4/1/98-12/31/98.

The goal of the biennial Northwest Health Policy Research Conference is to promote communication and more effective collaboration between the health policy and research communities in the Pacific Northwest; provide an opportunity for researchers to hear directly about research issues of

importance to policymakers; and bring the findings of relevant health and health care research directly to policymakers. The 1998 conference offered two plenary sessions; seven concurrent morning and afternoon breakout sessions presenting original research; three workshops; and a poster session. Speakers represented public- and private-sector health and health policy researchers, analysts, and funding organizations. (Abstract and conference proceedings, NTIS accession no. PB2002-108000; 32 pp, \$25.50 paper, \$12.00 microfiche)***

Outcomes of Hospital Outcome Studies. Patrick Romano, M.D., M.P.H., University of California, Davis. AHRQ grant HS08574, project period 9/30/94-10/31/99.

The goal of this study was to evaluate the impact of hospital report cards in New York and California. The researchers conducted mail and telephone surveys of hospital administrators, quality improvement leaders, and managed care executives, and they analyzed hospital discharge data to ascertain effects on consumer choice. Hospital administrators and quality improvement leaders attend to report cards but remain skeptical about their quality and value. New York's report, based on detailed clinical data, received better ratings than California's report, which was based on administrative data. Administrators at low-mortality hospitals rated the report better and found it to be more useful than those elsewhere. A few quality improvement leaders described projects resulting from public disclosure; most expressed frustration at the untimely publication schedule and the lack of actionable information about care. There is substantial interest in hospital quality among managed care executives, but objective data

receive little attention in contracting. Health plans rely more on quality measures with poor discrimination (i.e., accreditation) or subjective concepts (i.e., reputation, commitment to quality improvement, member satisfaction). Report cards had modest, inconsistent, and transient effects on consumer choice of hospitals. Volume shifts were greater among white and HMO-enrolled patients (in California) than among others. (Abstract, executive summary, and final report, NTIS accession no. PB2002-108741; 90 pp, \$29.50 paper, \$12.00 microfiche)***

Pediatric Internet Medical Advice and Triage. Larry J. Baraff, M.D., University of California, Los Angeles. AHRQ grant HS10604, project period 9/30/99 to 9/29/01.

With the widespread dissemination of Internet technology, consumers have increased access to medical information via the Internet and to medical providers via e-mail. The objective of this project, which involved a self-administered survey, was to determine sources and quality of medical advice and information used by parents and whether parents would like to communicate with health care providers by e-mail. The study took place among consecutive parents visiting a general pediatrics faculty practice at a university medical center. The main outcome measure was reported quality of medical advice from physicians, nurse practitioners, the Internet, family and friends, and books, and the actual and desired use of e-mail to communicate with health care providers. The majority of 1,108 subjects had both Internet access (91.5 percent) and an e-mail address (87.6 percent). Approximately half used the Internet for medical information,

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and 30 percent used it to obtain information about a specific acute or chronic medical illness. Only 15 percent had communicated with a physician by e-mail in the previous year; however, an additional 49 percent said they would like to do so. Though at least 76 percent rated physician advice as very good or excellent by phone or at the time of the visit, only 47 percent considered medical information they had obtained via the Internet to be very good or excellent. (Abstract,

executive summary, and final report, NTIS accession no. PB2002-108738; 88 pp, \$29.50 paper, \$12.00 microfiche)***

***Spouse Involvement in Cardiac Patients' Exercise Behavior Change.* Tantina Hong, Ph.D., Wayne State University, Detroit, MI. AHRQ grant HS11263, project period 9/30/00-9/29/01.**

In light of the known benefits of health promoting behavior such as exercise in forestalling the disability associated with heart disease, the current study focused on examining

the social processes underlying exercise behavior change in married couples. Participants were 80 patients and spouses enrolled in cardiac care. There was evidence that couples sharing the experiences in the same stage of behavior change are more in agreement in their perceptions of support and control exchanges than patients and spouses who are in different stages of change. (Abstract, executive summary, and final report, NTIS accession no. PB2002-104715; 136 pp, \$36.00 paper, \$17.00 microfiche)*** ■

Research Briefs

Farley, D.O., Short, P.F., Elliott, M.N., and others. (2002, August). "Effects of CAHPS health plan performance information on plan choices by New Jersey Medicaid beneficiaries." (AHRQ grant HS09204). *Health Services Research* 37(4), pp. 985-1007.

These researchers randomly assigned newly enrolled New Jersey Medicaid beneficiaries to a group that received the Consumer Assessment of Health Plans Study (CAHPS®) report (which provides consumer assessments of care in various health plans) and standard enrollment materials or a control group that received only the standard materials. Results showed that receipt of the CAHPS report along with the standard plan enrollment materials did not affect plan choice. However, only half of the Medicaid enrollees said they received and read the CAHPS report, and there was an HMO with dominant Medicaid market share but low CAHPS performance scores. Individuals who read the report and did not choose this dominant HMO chose HMOs

with higher CAHPS scores, on average, than the beneficiaries in the control group. The researchers conclude that health plan performance information can influence Medicaid plan choices, but the challenge is to get enrollees to actually read the information.

Fleishman, J.A., Spector, W.D., and Altman, B.M. (2002). "Impact of differential item functioning on age and gender differences in functional disability." *Journal of Gerontology: Social Sciences* 57B (5), pp. S275-S284.

People who are limited in their ability to perform basic daily activities—for example, bathing, eating, shopping, or managing finances—are functionally disabled. Individual functional disability is often measured by asking a person about their difficulty in performing certain tasks. However, estimates of group differences in functional disability may be biased if items exhibit differential item functioning (DIF). Comparisons of disability across sociodemographic groups

need to take DIF into account, conclude these investigators. They analyzed responses of 5,750 adults, who received help with at least one of 11 daily living tasks, to the 1994/1995 National Health Interview Survey Disability Supplement. Nine items manifested significant DIF by age or sex; DIF was especially large for shopping and money management. Without adjusting for DIF, middle-aged people were less disabled than elderly men, and women were less disabled than men among nonelderly people. However, after adjusting for DIF, middle-aged people did not differ from elderly people, and differences between men and women within age groups were not significant. Reprints (AHRQ Publication No. 03-R001) are available from AHRQ.**

Friedman, B., De La Mare, J., Andrews, R., and McKenzie, D.H. (2002, Fall). "Practical options for estimating cost of hospital

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inpatient stays.” *Journal of Health Care Finance* 29(1), p. 1-13.

Analysts often estimate the cost of hospital services by applying cost/charge (c/c) ratios from Federal or State data sources to the charges provided on hospital discharge records. However, a number of sources of discharge data do not permit the disclosure of hospital identities. This study supports a practical policy option of releasing group c/c ratios attached to discharge records when identity must be masked. The researchers compared several sources of c/c data for use in the restricted environment using accounting data from four State systems and from files of the Federal Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration or HCFA). In one analysis, they grouped hospitals by selected characteristics. They found that c/c varied by State and characteristics. Some CMS and State measures tracked each other closely. A wider analysis of hospital-specific data for 51 States and territories offered a separate test and extension of the initial results.

Matsumura, S., Bito, S., Liu, H., and others. (2002, July). “Acculturation of attitudes toward end-of-life care: A cross-cultural survey of Japanese Americans and Japanese.” *AHRQ grant HS07370*). *Journal of General Internal Medicine* 17, pp. 531-539.

In Japan, doctors rarely disclose a fatal diagnosis, especially cancer, to the patient, and the family takes the lead in health care decisionmaking. Also, the concept of advance care planning is unfamiliar in Japan. Japanese Americans have adopted some American attitudes toward end-of-life care, while retaining some traditional Japanese attitudes. The

researchers analyzed responses to questionnaires in English and Japanese from 539 English-speaking Japanese Americans (EJA), and 340 Japanese-speaking Japanese Americans (JJA) living in Los Angeles and from 304 Japanese living in Japan (JJ). A majority of each group wanted the family to make decisions about life-sustaining treatments (75 percent of EJA, 57 percent of JJA, and 69 percent of JJ). In contrast to EJA and JJA, about one-third of JJ preferred to withhold the terminal prognosis from the patient. Almost all respondents wanted family members to be informed of the diagnosis.

Schneeweiss, S., Maclure, M., Soumerai, S., and others. (2002). “Quasi-experimental longitudinal designs to evaluate drug benefit policy changes with low policy compliance.” (*AHRQ grants HS09855 and HS10881*). *Journal of Clinical Epidemiology* 55, pp. 833-841.

A causal relationship between drug benefit policy change and an increase in adverse outcomes can be tested by comparing the experience of a group of patients affected by the policy versus the (counterfactual) experience of the same patients if the policy had not been implemented. Because counterfactual experiences cannot be observed, it must be assumed that the counterfactual experience is correctly described by extrapolating from the same group’s previous experience. However, results from nonrandomized comparisons of specific subgroups defined by their reaction to a new policy in the middle of followup should be interpreted with caution, concludes this study. The null hypothesis of no policy effect can be empirically tested using quasi-experimental longitudinal designs with repeated measures. If compliance to a policy is low, results may be biased toward the null, but a subgroup analysis of

those who comply may be biased by treatment selection. Using the example of reference drug pricing in British Columbia, these authors discuss assumptions for causal interpretations of such analyses and provide supplementary analyses to assess and improve the validity of findings.

Weinberger, M., Murray, M.D., Marrero, D.G., and others. (2002, August). “Issues in conducting randomized controlled trials of health services research interventions in nonacademic practice settings: The case of retail pharmacies.” (*AHRQ grant HS09083*). *Health Services Research* 37(4), pp. 1067-1077.

Health services researchers often conduct randomized controlled trials (RCTs) in academic or other clinical settings in which the investigator has a reasonable degree of control over factors essential to conducting a well-designed RCT. However, health services researchers should conduct RCTs in a variety of nonacademic practice settings to increase the generalizability of their findings and better reflect the true impact of interventions. Pragmatic problems, although significant, can be successfully overcome, assert these researchers. They conducted an RCT to evaluate the effectiveness of an intervention to increase pharmacists’ involvement in caring for customers at 36 retail drug stores in Indianapolis. Major modifications in research design were necessitated by factors such as corporate restructuring, heightened sensitivity to patient confidentiality, and difficulties in altering employees’ behavior. They overcame these barriers by conducting research that was consistent with corporate goals, involving appropriate corporate administrators and technical personnel early in the process, and remaining flexible. ■

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