AHRQ

Research Activities

No. 242, October 2000

Highlights

Departments

Regular Features

Depending on how it's measured, health plan performance may vary by enrollee ethnicity, education, and income

Performance on the standardized measures used by the Nation's health insurers when computing their scores through the Health Plan Employer Data Set (HEDIS) is influenced by factors such as enrollee schooling, income, and ethnic or racial background, according to a recent study. HEDIS is a reporting tool that monitors how well health plans perform essential medical services. The study was led by researchers at Harvard Medical School supported by the Agency for Healthcare Research and Quality (HS09473).

These findings are particularly important because health insurance contracting decisions by large employers and other health plan purchasers and plan selection by individual consumers can be influenced by how well a health plan performs on HEDIS measures. The tool, which was developed and is administered by the National Committee for Quality Assurance (NCQA), is commonly used by managed care plans throughout the United States.

Lead author Alan M. Zaslavsky, Ph.D., an Associate Professor in the Harvard Medical School's Department of Health Care Policy, and fellow researchers from Harvard, NCQA, and other institutions sought to determine whether the quality of care delivered by health plans varies across different populations. To do this, the researchers looked at how the characteristics of enrollees' neighborhoods were related to outcomes on the HEDIS quality measures.

The investigators found that within each health plan, certain populations from areas with relatively high percentages of residents on welfare or who were black or Hispanic received generally poorer quality of care, while enrollees in urban areas and areas with higher educational levels and more Asian-American residents received consistently better care. Although previous studies have found that minority, low-income, and poorly educated patients under-use essential medical services, what's striking about these findings is that they

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Health plan performance

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represent differences among commercially insured patients within the same health plans, according to Dr. Zaslavsky. He also noted that the findings underscore the importance of determining the appropriate role for case-mix adjustment—a method used to make adjustments for the composition of a plan's enrollees to permit a more accurate assessment of quality of care provided by the plan. Dr. Zaslavsky pointed out that further work with more detailed adjustments which go beyond geographic proxies for the characteristics of enrollees will be needed to determine the underlying causes of the variations observed in this study.

The findings are based on data from 112,397 enrollees of 10 managed care plans in different parts of the United States. The study resulted from an AHRQ-funded project–the ongoing development and evaluation of HEDIS measures—led by Harvard's Arnold M. Epstein, M.D., and Paul D. Cleary, Ph.D. The project is part of an AHRQ program to strengthen the science base of quality measurement while expanding the scope and availability of validated, ready-to-use measures .

Details of the study summarized here are in "Impact of sociodemographic case mix on the HEDIS measures of health plan quality," in the October 2000 *Medical Care*, 38(10), pp. 981-992. ■

Health Care Costs and Financing

Costs are no higher for Medicaid children than for privately insured children in the same HMO

Growing numbers of Medicaid-insured children have been enrolled in managed care plans nationwide. However, many large commercial managed care plans are discontinuing their participation in Medicaid because of low reimbursement rates. A newly published study has found that Medicaid-insured and privately insured children in the same HMO had similar medical expenses. Only Medicaid children who were medically needy, blind, or disabled had substantially higher costs.

These results suggest that it may become necessary for States that want to continue enrolling Medicaid recipients in HMOs to adopt reimbursement levels that are comparable to rates set for commercially insured patients. States also may need to incorporate adequate risk-adjustment mechanisms to determine reimbursement for children with special needs, conclude the Kaiser Permanente of Northern California researchers who led the study. Agency for Healthcare Research and Quality investigators Robin M. Weinick, Ph.D., and Joel W. Cohen, Ph.D., were collaborators in this study.

The researchers compared the health care use and costs of children with Medicaid and children with commercial insurance within the same large California HMO between 1995 and 1997. About 9 percent of Medicaid-insured children were medically needy, and 4 percent were blind or disabled. Income-eligible Medicaid- insured and commercially insured groups of children had similar use of outpatient services such as clinic and hospital outpatient visits. However, Medicaid-insured medically needy children had significantly more clinic visits than their commercially insured counterparts (5.2 vs. 3.6), and blind or

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Costs for children in HMOs

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disabled Medicaid enrollees had significantly more hospital outpatient visits (0.09 vs. 0.03) and clinic visits (5.6 vs 3.6) compared with commercially insured children.

Overall, income-eligible Medicaid-insured and commercially insured children had costs of about $60 per month. The medically needy were substantially more costly than the commercially insured ($81 vs. $61 per month), mostly due to increased outpatient clinic costs ($12 more per month) and emergency department costs ($3 more per month). Blind and disabled children also were substantially more costly than commercially insured children ($277 vs. $61 per month). These costs followed adjustment for age, sex, and whether the child had joined the HMO within 2 months of birth (a costly time).

See "Comparing the medical expenses of children with Medicaid and commercial insurance in an HMO," by G. Thomas Ray, M.B.A., Tracy Lieu, M.D., M.P.H., Dr. Weinick, and others in the July 2000 *American Journal of Managed Care* 6(7), pp. 753-760. Reprints (AHRQ Publication No. 00-R044) are available from AHRQ.** ■

Primary Care

Availability of free vaccines affects clinicians' decisions about referring uninsured children to public clinics

The Federal Vaccines for Children Program (VFC) provides States with free vaccines that are distributed to both private providers and public clinics for use in immunizing poor children. A 1997 survey of pediatric nurse practitioners (PNPs) found that PNPs who received free vaccine supplies were less likely than those who did not to refer children to public clinics for vaccinations. Eight percent of PNPs who received vaccines compared with 7 percent who did not receive them referred a privately insured child to a public clinic, 10 percent vs. 27 percent referred a Medicaid-insured child, and 46 percent vs. 67 percent referred an uninsured child to a public clinic.

These results are similar to a 1995 survey of physicians. In 1997, 82 percent of PNPs received free vaccines compared with only 52 percent of physicians in 1995. PNPs estimated that vaccination costs deterred only about 1 percent of children from receiving immunizations at the appropriate age. They estimated that a median of 10 percent of children in their practices received more than half of their vaccines from a health department or public clinic. Most (86 percent) of the PNPs in this study who were participating in the VFC program said they were very satisfied with the program.

Although referring children from primary care offices to public vaccine clinics is preferable to not vaccinating them, there are disadvantages. First a child may visit the public vaccine clinic later and thus have a greater window of time when he or she is not age-appropriately vaccinated and thus is susceptible to diseases that can be prevented. Second, fragmentation of care occurs, with an increased burden and expense for the parents of taking the child to one site for vaccines and another site for well-child care and other services.

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Also in this issue:

Availability of free vaccines

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Also, medical records may not be easily transferred from one site to another, note Richard Kent Zimmerman, M.D., M.P.H., and his University of Pittsburgh colleagues. Their survey, which was supported by the Agency for Healthcare Research and Quality (HS09527), included telephone interviews with a national random sample of primary care PNPs.

See "Does the Vaccines for Children Program influence pediatric nurse practitioner referral of disadvantaged children to public vaccine clinics?" by Dr. Zimmerman, Susan N. VanCleve, M.S.N., Anne R. Medsger, R.N., M.S.Hyg., and others, in the *Maternal and Child Health Journal* 4(1), pp. 53-58, 2000. ■

No link found between referrals to specialty care and patients' health status or risk of avoidable hospitalization

Managed care organizations have been criticized for their use of primary care providers (PCPs) as gatekeepers to control access to specialists as a mechanism to hold down costs. However, a new study shows that the rate at which PCPs refer patients to specialists has little impact on patient costs or outcomes. Thus, efforts to constrain PCP referrals to specialists may be misguided, according to Peter Franks, M.D., and his colleagues at the University of Rochester.

In the study, which was supported by the Agency for Healthcare Research and Quality (HS09397), they analyzed claims data and patient survey data to examine the relationships between PCP referral rates and patient costs, health status, risk of avoidable hospitalization, and care satisfaction. The 1995 claims data included 457 PCPs in an independent practice association and 217,606 adult patients. The survey included 50 patients each from 100 PCPs in 1997-1998.

Unlike previous studies that showed higher costs related to referrals, this study adjusted for differences in patient case mix. After this adjustment, the researchers found no significant relationship between PCP referral rate and costs or patient risk of avoidable hospitalization. The survey data revealed no relationship between the PCP referral rate and patients' self-rated physical or mental health. However, patients of physicians with higher referral rates were slightly more satisfied than were patients of physicians with lower referral rates.

Overall, referral rate by itself was not an important determinant of patient outcomes. Although these results should not suggest that open access to specialists will be cost-n eutral, they do not support efforts to reduce referrals by PCPs. The authors also note that containment strategies that restrict referrals to specialists set the stage for competition among specialists and PCPs that may have deleterious effects. Also, more restricted access to specialists is associated with lower patient satisfaction.

See "Physician referral rates: Style without much substance?" by Dr. Franks, Cathleen Mooney, M.S., and Melony Sorbero, M.S., in the August 2000 *Medical Care* 38(8), pp. 836-846. ■

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.

Risk of foot amputation may be double for diabetes patients who don't obtain prescribed footwear and medicines

Patients with diabetes often develop blisters and cuts that do not heal, leading to infection and sometimes an amputation. The American Diabetes Association recommends a yearly foot exam for patients with diabetes to prevent the complications of foot ulcers and amputation, but there is little research to support this recommendation.

Robert G. Nelson, M.D., Ph.D., who was with the National Institute of Diabetes and Digestive and Kidney Disease at the time of this research, and his colleagues undertook a population-based, retrospective case-control evaluation to assess the value of foot exams. The study was supported by the Agency for Healthcare Research and Quality and conducted with the Pima Indians, a group in which the prevalence of diabetes and diabetes-associated amputation is among the highest in the world.

The researchers reviewed the medical records of 61 diabetic patients who had undergone amputation to assess the frequency of foot exams provided during the 3 years prior to the amputation. They also reviewed the medical records for 183 diabetic controls who had not undergone an amputation. Over the 3 years, the 244 diabetic patients received 1,857 foot examinations. Almost one-third of the foot exams were for wound care. The remainder were considered to be preventive and included foot screening, footwear fitting, debridement of callus and nails, and foot care education. After controlling for differences in health status and foot-risk conditions, the risk of amputation for people who received one or more preventive foot exams over the 3 years was 0.55, but the result was not statistically significant.

The researchers also assessed the number of times patients were prescribed foot wear and received the foot wear. The four patients who required molded shoes (a customized shoe required for severe foot deformities) received the footwear, but most of the other types of therapeutic footwear, including depth shoes and inserts, were not available at that time and thus were not obtained by the patients. The researchers suggest that the lack of statistical significance may have been due not only to the small sample size, but also to the lack of footwear availability at the time of the study for people with high-risk foot conditions.

The researchers also noted any record of compliance problems with diabetes care for foot care. Notations in the chart regarding poor compliance were associated with a two-fold increased risk of amputation, but again, the results were not statistically significant. The findings from this study suggest that foot exams may be associated with a decrease in amputation risk. Identification of a foot problem should be followed by appropriate treatments in order to prevent serious complications. The necessary footwear is now available for this patient population.

See "Do foot examinations reduce the risk of diabetic amputation?" by Jennifer Mayfield, M.D., M.P.H., Gayle E. Reiber, M.P.H., Ph.D., Dr. Nelson, and Tom Greene, Ph.D., in the June 2000 *Journal of Family Practice* 49(6), pp. 499-504 ■

Patients living with juvenile diabetes experience both the joy of life and a constant threat of serious complications

When insulin was introduced in 1922, it dramatically improved the lives of emaciated youngsters with diabetes who had been kept barely alive through "starvation diets." Insulin transformed juvenile diabetes, or type 1 diabetes mellitus, from a fatal disease into a chronic and often debilitating condition. Now those with juvenile diabetes can live near-normal lives if they carefully watch their diet, exercise, and take their medication. Yet they still face long-term damage to their eyes, kidneys, and blood vessels, as well as the daily burden of living with a chronic illness.

Attitudes adopted early toward their illness can lead to emotional and ethical predicaments, notes Chris Feudtner, Ph.D., of the University of Washington School of Medicine, in a recent commentary. These predicaments, which arise chiefly from living in the shadow of a threat to health, frequently involve issues of control, stigma, risk, and responsibility. First, how can a patient live with a danger that eludes full control, and how can a sense of safety be enhanced without resorting to false reassurances (you won't have any complications if you do everything right), magical thinking, or judgmental moralizing (you wouldn't have

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Juvenile diabetes

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had these complications if you had watched your diet and medication more closely).

Second, how can health care mitigate the stigma that accompanies life-threatening conditions, reducing its detrimental effects on self-concept and preventing social injustice? The author gives an example of how one patient almost did not get a job because a previous diabetic employee, who did not control his diabetes, had slipped into a diabetic coma several times on the job.

Third, how can risk assessment be incorporated into a vibrant care plan, allowing patients to move ahead joyously with life while addressing the threat of future dangers? Finally, how should the responsibility for the complications of diabetes be apportioned between patients and physicians?

Dr. Feudtner, whose work is supported by the Agency for Healthcare Research and Quality (National Research Service Award training grant T32 HS00009 and HS07476), notes that advances in medical therapy will continue to keep patients with chronic diseases living longer in states of what she calls "dangerous safety." Dr. Feudtner calls for a change in our fundamental perspective on health needs to integrate the inescapable threats of illness and death into the concept of a well-lived life.

More details are in "The predicaments of `dangerous safety': Living with juvenile diabetes in 20th century America," by Dr. Feudtner, in the July 2000 *Culture and Medicine* 173, pp. 64-67. ■

Long-Term Care

Study findings suggest segregation in nursing homes may exist in some areas

Certain organizational and community factors may influence racial differences in access to and quality of nursing home care. For instance, some nursing homes close to one another in the same community have a very different mix of black and white residents. This suggests that nursing home segregation exists. However, it is difficult to disentangle this segregation from the underlying geographic segregation, according to the Brown University researchers who conducted the study. They studied racial mix in nursing homes and the surrounding communities in four States: Kansas, Mississippi, New York, and Ohio. This research was supported in part by the Agency for Healthcare Research and Quality (HS10322) and led by Mary L. Fennell, Ph.D.

Generally, the proportion of blacks residing in the nursing homes within a county resembled the mix of blacks in the county's population. However, certain exceptions provided evidence of segregation. For instance, in Kansas counties where there were no blacks, 94 percent of nursing homes had no black residents, 4 percent had a 0.1 to 5 percent mix of black residents, and only 2 percent had 5.1 to 10 percent blacks. Yet in Mississippi, there were numerous counties with 20 percent or more blacks who had only one nursing home. That nursing home typically had a black mix of less than 5 percent or 5 to 20 percent of residents. In fact, in counties where the population was 20 percent black, only 58 percent of nursing homes had 20 percent or more black residents; in 11 percent of nursing homes, less than 5 percent of residents were black.

The opposite was true in New York, where blacks represented .1 to 5 percent of the population in 87 percent of the counties. In these counties, 7 percent of nursing homes had a patient mix that was greater than 10 percent black, but 32 percent of homes had no black residents. In Ohio, no county was more than 20 percent black, and 86 percent of counties were less than 5 percent black. Nursing home residents in primarily white counties tended to mirror those demographics. However, in counties where blacks made up 5 to 20 percent of the population, 28 percent of nursing homes had larger proportions of black residents than observed for the county populations.

See "Facility effects on racial differences in nursing home quality of care," by Dr. Fennell, Susan C. Miller, Ph.D., M.B.A., and Vincent Mor, Ph.D., in the July/August 2000 *American Journal of Medical Quality* 15(4), pp. 174-181. ■

Followup of low birthweight babies to adolescence reveals many have learning and behavioral problems

Adolescents who weighed only 2 pounds or less at birth (very low birthweight, VLBW) suffer from more school difficulties and behavioral problems than their normal birthweight (NBW) peers, concludes a review of studies of six cohorts of infants born in the United States, Canada, Australia, and the United Kingdom. Extremely low birthweight (ELBW) adolescents (less than 750 g or 1.6 lbs) fared the worst on all behavioral, cognitive, and achievement measures, and they performed particularly poorly in mathematics. From 15 to 20 percent of VLBW and 30 to 50 percent of ELBW adolescents were receiving remedial assistance and/or had failed a grade.

ELBW adolescents had mean IQ scores 8 to 13 points lower than NBW adolescents, and 11 to 17 percent of ELBW adolescents had IQ scores below 70 compared with 0 to 7 percent of NBW peers. ELBW children also scored lower on standardized tests; 23 percent scored lower than 70 in reading, 24 percent scored that low in spelling, and 37 percent scored that low in math, compared with 2 percent, 2 percent, and 4 percent, respectively, of NBW adolescents. The likelihood of adolescents scoring less than 85 on these subjects was 8- to 13-fold higher for those who weighed less than 1.6 pounds at birth and 4- to 6-fold higher for those whose birthweight was 1.6 to 2.2 pounds (VLBW), compared with their NBW peers.

Most investigators reported that a significant proportion of VLBW children had school difficulties that required special educational assistance and/or grade repetition, according to Saroj Saigal, M.D., F.R.C.P., of McMaster University. Dr. Saigal's work was supported in part by the Agency for Healthcare Research and Quality (HS08385).

Parents in one study reported that 64 percent of ELBW children were in regular classrooms, 46 percent were receiving remedial assistance, and 21 percent had repeated a grade. Learning disabilities ranked among the most common problems among school-aged VLBW children. Apparently, earlier deficits do not resolve with time. In fact, in some areas, such as math, the problems became more apparent as the complexity of the tasks increased with age. Several studies also suggested that VLBW adolescents were at risk for a wide array of emotional and behavioral disorders, particularly attention deficit hyperactivity disorder (ADHD). A recent study suggests that atrophy of the corpus callosum part of the brain may account for the poor school performance of VLBW survivors, notes Dr. Saigal.

More details are in "Follow-up of very low birthweight babies to adolescence," by Dr. Saigal, in *Seminars on Neonatology* 5, pp. 107-118, 2000. ■

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Use of interactive voice response systems by patients with chronic diseases can improve outcomes

Interactive voice response (IVR) systems can moderately improve the outcomes of patients with chronic diseases such as diabetes, back pain, and depression, according to this review of research conducted between 1985 and 1999. IVR assessment can indicate when a diabetes patient's blood sugar level is too high, when a person is struggling with depression, or when back pain is negatively affecting a patient's quality of life.

Patients using IVR receive recorded messages and report clinical information using their telephone touch tone keypad or voice recognition technology. Patients are more likely to report sensitive information accurately in their interactions with IVR systems than they are during in-person interviews. Also, patients can access IVR systems more frequently and conveniently than a doctor's office or outpatient clinic, explains John D. Piette, Ph.D., of the VA Center for Health Care Evaluation and Stanford University. Dr. Piette's work was supported by the Agency for Healthcare Research and Quality (HS10281).

The studies reviewed by Dr. Piette showed the benefit of IVR systems on patient outcomes. For example, in one study patients with diabetes who used an IVR system to obtain health information, report changes in blood glucose control, and access a decision-support system for making insulin dose adjustments had a three-fold decrease in diabetes crises and an average in glycosylated hemoglobin of 0.8 percent (absolute). Another study showed that diabetes patients who used an IVR system had improved self-care and fewer symptoms of poor glycemic control than similar patients who received usual care.

Nurse educators used IVR assessment information to identify patients needing additional counseling which was provided via followup telephone calls. Patients using the IVR system also reported fewer symptoms of depression and days in bed due to illness than patients receiving usual care. In addition, another study found that hypertensive patients who received weekly IVR monitoring with feedback of their assessment data to physicians had improved medication adherence and decreased diastolic blood pressure compared with usual care patients.

These studies suggest that IVR assessments may be a useful adjunct to care for patients with a variety of chronic physical and mental illness. Patients who face barriers to self-management—such as lack of social support, poor English competence, poor health literacy, or mental health problems–may benefit even more from the additional oversight afforded by periodic IVR assessments.

See "Interactive voice response systems in the diagnosis and management of chronic disease," by Dr. Piette, in the July 2000 *American Journal of Managed Care* 6(7), pp. 817-827. ■

Evidence-Based Medicine

Studies point the way to cholesterol screening recommendations for women

As women age, their risk of coronary heart disease (CHD) increases. Women currently account for half of all CHD deaths in the United States, and many studies have reported an association between CHD and high levels of total cholesterol (TC) and low-density lipoprotein cholesterol (LDL-C), the so-called bad cholesterol. Questions persist about the best cholesterol screening strategy for women to detect high cholesterol that can lead to CHD.

After reviewing recent studies on the impact of cholesterol screening in women on cholesterol reduction and CHD, David Atkins, M.D., M.P.H., and his colleagues discuss recommendations from national organizations and findings from recent large treatment trials on cholesterol screening in women. Dr. Atkins is Coordinator for Clinical Preventive Services at the Center for Practice and Technology Assessment, Agency for Healthcare Research and Quality.

The researchers note that periodically measuring TC and HDL-C in all middle-age women

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Cholesterol screening for women

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and in younger women with diabetes or other major risk factors will detect most women with sufficiently high cholesterol to warrant statin drug therapy or intensive lifestyle interventions. For the remainder of average-risk younger women, more concerted efforts to promote smoking cessation, regular physical activity, healthy weight, and diets low in saturated fat and high in fruits and vegetables are probably more important than lipid screening.

The National Cholesterol Education Program guidelines recommend measuring nonfasting TC and HDL-C every 5 years in women beginning at age 20. The U.S. Preventive Services Task Force and American College of Physicians recommend beginning routine cholesterol screening of average-risk women at age 45, and perhaps earlier screening for high-risk women (those with multiple risk factors, diabetes, strong family history). All organizations recommend advising all patients to reduce dietary saturated fat, maintain a healthy weight, and increase physical activity. The benefits of lipid reduction for women who have both high LDL-C and high HDL-C (the so-called good cholesterol) remains an important but unsettled question.

For more details, see "Lipid screening in women," by Dr. Atkins, Judith M. Walsh, M.D., M.P.H., Michael Pignone, M.D., M.P.H., and Christopher J. Phillips, M.D., M.P.H., in the Summer 2000 *Journal of the American Medical Women's Association* 55(4), pp. 234-240. Reprints (AHRQ Publication No. 00-R043) are available from AHRQ.** ■

AHRQ releases three new evidence reports

Three new evidence reports were released recently by the Agency for Healthcare Research and Quality. They represent the results of systematic reviews of the evidence on management of acute exacerbations of chronic obstructive pulmonary disease, prevention of venous thromboembolism after injury, and use of dietary garlic. The reports were prepared by Evidence-based Practice Centers (EPCs) supported by the Agency for Healthcare Research and Quality. They provide organizations with comprehensive, science-based information on common, costly medical conditions and new health care technologies.

There are 12 AHRQ-supported EPCs; they systematically review the relevant scientific literature on topics assigned to them by AHRQ and conduct additional analyses when appropriate prior to developing their reports and assessments. The goal is to inform health plans, providers, purchasers, and the health care system as a whole by providing essential information to improve health care quality. Evidence report summaries are now available from AHRQ, both online and in print from the AHRQ Clearinghouse. Copies of the full evidence reports will be available in the near future.

Management of Acute Exacerbations of Chronic Obstructive Pulmonary Disease. The Duke University Evidence-based Practice Center (Contract no. 290-97-0014) assessed the evidence currently available concerning the diagnosis, prognosis, and management of acute exacerbations of chronic obstructive pulmonary disease (COPD). COPD, which affects 16 million people and leads to nearly 300,000 hospitalizations annually, is the fourth leading cause of death in the United States. Acute exacerbations of COPD—worsening symptoms of dyspnea and an increase in the amount or purulence of sputum, which may be accompanied by chest discomfort, fever, and other symptoms—are associated with increased short-term mortality when compared with stable COPD.

This report discusses the evidence on clinical assessment of acute exacerbations of COPD (differential diagnosis, prediction of outcome, and level-of-care needs), the effectiveness of various treatments, and the use of noninvasive positive-pressure ventilation in patients with acute exacerbations who have developed respiratory failure. The EPC also provides recommendations for future research.

Copies of the report summary (AHRQ Publication No. 00-E020) are available from AHRQ.** Copies of the full report (AHRQ Publication No. 01-E003) will be available from AHRQ in winter 2000.*

Prevention of Venous Thromboembolism After Injury. Venous thromboembolism (VT) is an injury-related blood-clotting problem that results in 50,000 deaths and 300,000 to 600,000 hospitalizations annually in the United States. Methods for preventing VT include sequential compression devices, low-dose heparin, low-molecular-weight heparin, vena caval filters, and combinations of these. All of these methods are associated with

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New evidence reports

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contraindications and morbidity, which complicates selection of the appropriate method for each patient. This, in turn, leads to wide variability among physicians and prevents consistency in quality of care.

The Southern California Evidence-based Practice Center/RAND (AHRQ contract 290-97-0001) developed this evidence report on prevention of VT after trauma. Their goals were to identify the best method to prevent VT, determine which group of trauma patients are at high risk for developing VT, identify the best method of screening for the problem, and assess the role of vena caval filters in preventing one form of VT (pulmonary embolism) after injury. The report presents their findings and results of meta analyses, identifies gaps in the research literature, and provides recommendations for future research.

Copies of the report summary (AHRQ Publication No. 00-E026) are available from AHRQ.** Copies of the full report (AHRQ Publication No. 01-E004) will be available in winter 2000.*

Garlic: Effects on Cardiovascular Risks and Disease, Protective Effects Against Cancer, and Clinical Adverse Effects. Dietary use of garlic may lower some types of cholesterol in the short term, but it does not appear to offer long-term protection against cardiovascular disease, according to this evidence report. Garlic may help to reduce low-density lipids (LDL), or "bad" cholesterol and triglycerides, but the evidence suggests only short-term (1 to 3 months) effects. Long-term benefits, if any, have not been determined. The levels of high-density lipids (HDL), or "good" cholesterol, were unaffected. After 6 months, no further reductions in either triglycerides or LDL were apparent. The report calls for additional research to examine the short-term versus long-term benefits of garlic consumption.

The report, which was based on a systematic review and analysis of scientific evidence related to clinical studies of garlic in humans, was prepared for AHRQ by the Evidence-based Practice Center at the University of Texas Health Science Center at San Antonio and the Veterans Evidence-based Research, Dissemination, and Implementation Center (VERDICT), a Veterans Affairs Health Services Research and Development Center of Excellence.

The authors found no evidence that garlic has a beneficial impact on blood pressure or diabetes, and evidence was inconclusive about garlic's role in protecting against cancer. Dietary garlic may possibly be associated with a decreased likelihood of some types of cancer, but the number of available studies was not sufficient to draw conclusions. Also, there is not enough evidence on the different garlic preparations, such as raw, cooked, or supplement form.

A summary of Evidence Report Number 20 (AHRQ Publication No. 00-E022) is available from AHRQ.** Print copies of the full report (AHRQ Publication No. 01-E023) are expected in winter 2000.** ■

Agency News and Notes

AHRQ congratulates recent recipients of research training awards

We congratulate all applicants who have recently received research training grant awards from the Agency for Healthcare Research and Quality. To all recipients, we wish you well as you build a knowledge base, gain research skills, and develop your abilities towards becoming outstanding health services researchers. We also acknowledge and thank mentors and advisors of these new grantees for their invaluable leadership and guidance.

Career Development Awards

Nancy Birkmeyer
HS11288
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Christopher Blackmore
HS11291
University of Washington
Mentor: Peter Cummings

Kenley Chin
HS00012
University of California, Los Angeles
Mentor: Katherine Kahn

Kenneth Covinsky
HS00006
University of California, San Francisco

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John Feudtner
HS00002
University of Washington
Mentor: Thomas Koepsell

Glenn Flores
HS11305
Boston Medical Center

Christopher Forrest
HS00003
Johns Hopkins University

Laurent Glance
HS11295
University of Rochester
Mentor: Thomas Pearson

Jeanne-Marie Guise
HS11338
Oregon Health Sciences University
Mentor: Mark Helfand

Sarah Hawley
HS00007
Baylor College of Medicine

Pamela Jenkins
HS00010
Dartmouth College
Mentor: Gerald O'Connor

Marielena Lara
HS00008
University of California,
Los Angeles
Mentor: Robert Brook

Anthony Losasso
HS11294
Northwestern University

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HS00004
University of Pennsylvania
Mentor: Peter Ubel

David Studdert.
HS11285
Harvard University

Simon Whitney
HS11289
Baylor College of Medicine
Mentor: Robert Volk

Dissertation Awards

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University of North Carolina at
Chapel Hill
Advisor: Edward Norton

Jason Brown
HS11268
Brown University
Advisor: Mark McClellan

Tantina Hong
HS11263
Wayne State University
Advisor: Melissa Franks

Christa Kelleher
HS10790
Brandeis University
Advisor: Peter Conrad

Amanda Liddle
HS11259
University of Alabama,
Birmingham
Advisor: Donna Petersen

Jacquelyne Luce
HS11266
York University, Toronto
Advisor: Naomi Adelson

Jennifer Miglionico
HS10789
Dartmouth College
Advisor: Margaret Karagas

Mary Milidonis
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HS11271
University of California, Berkeley
Advisor: Stephen Shortell

Noelle Molinari
HS11275
Wayne State University
Advisor: Allen Goodman

Brian Quilliam
HS11256
Brown University
Advisor: Vincent Mor

Kandyce Richards
HS10788
University of Miami School
of Nursing
Advisor: Nancy Hogan

Heidi Silver
HS11276
Florida International University
Advisor: Nancy Wellman

Meredith Silverstein
HS11269
University of Colorado Health
Science Center
Advisor: Stacy Zamudio

Carolyn Smith
HS10802
University of Arizona, Tucson
Advisor: Ana Ortiz

Elizabeth Trice
HS11274
University of Minnesota
Advisor: Roger Feldman

Xin Wang
HS11277
University of Illinois, Chicago
Advisor: Carol Braunschweig

Whitney Witt
HS11254
Johns Hopkins University
Advisor: Anne Riley

Predoctoral Fellowship Awards

Tanisha Carino
F31 HS00150-
Johns Hopkins University
Advisor: Christopher Forrest

Matthew Hudson
F31 HS11280
Dartmouth College
Advisor: Ann Flood

Postdoctoral Fellowship Awards

Frank Day
F32 HS00141
University of California,
Los Angeles
Mentor: David Schriger

Jinah Shin
F32 HS00149
Columbia University
Mentor: Kristine Gebbie ■

AHRQ supports 19 primary care practice-based research networks

The Agency for Healthcare Research and Quality has awarded 19 exploratory grants to support 1-year planning efforts by primary care practice-based research networks (PBRNs). Together, these PBRNs will be able to engage in research with over 5,000 primary care providers and nearly 7 million patients in a variety of primary care practice settings across the United States.

AHRQ will provide over $2 million this year to support PBRN planning activities. Each grant will support the development of a PBRN plan to enhance the network's capacity to collect and analyze primary care data, study the health care of minority and underserved populations, and translate new research findings into practice. After successful completion of the planning phase, the 19 PBRNs will be able to compete for AHRQ funding for primary care research in key areas, such as patient safety and reducing health care disparities.

The PBRN institutions and principal investigators receiving AHRQ planning grants are:

- American Academy of Family Physicians, Leawood, KS. The AAFP National Network for Family Practice and Primary Care Research is an emerging network that includes 110 clinicians from practices in 34 States and 4 Canadian provinces. Herbert F. Young, M.D., M.A. $121,388.

- American Academy of Pediatrics, Elk Grove Village, IL and University of Vermont, Burlington, VT. Pediatric Research in Office Settings (PROS) is a national network that includes practitioners from 540 pediatric practices in 49 States, Puerto Rico, and Canada. Richard C. Wasserman, M.D., M.P.H. $112,420.

- Baylor College of Medicine, Houston, TX. The Baylor Practice-Based Research Network is an urban-based network whose purpose is to evaluate the effectiveness of primary care services delivered to ethnically and socioeconomically diverse populations in Houston. Robert J. Volk, Ph.D. $110,089.

- Case Western Reserve University, Cleveland, OH. The Research Association of Practicing Physicians is a network of 116 practices in northeast Ohio that focuses on the structures, processes, and outcomes of primary care practice. Kurt C. Stange, M.D., Ph.D. $108,578.

- Children's Memorial Hospital, Chicago, IL. The Pediatric Practice Research Group is a Chicago-area network that for 16 years has been conducting studies on primary care for children. Katherine Christoffel, M.D., M.P.H. $108,000.

- Children's Hospital Center, Cincinnati, OH. The Cincinnati Pediatric Research Group was established in 1996 to study a geographically and socioeconomically diverse pediatric population served by an array of health care facilities. Michele Kiely, Ph.D. $111,000.

- Dartmouth Medical School, Hanover, NH. The Dartmouth/Northern New England Primary Care Cooperative Research Network is the oldest primary care practice-based research network in the country and is composed chiefly of independent primary care clinicians who reside in New Hampshire, Maine, and Vermont. John H. Wasson, M.D. $142,970.

- Indiana University, Indianapolis, IN. Wishard Health Services and the primary care practices of the Indianapolis University School of Medicine have created ResNet, a research network that conducts studies related to medical informatics and the translation of research into clinical practice. William M. Tierney, M.D. $134,008.

- Michigan State University, East Lansing, MI. The Great Lakes Research into Practice Network is a new, large network created through the merger of three established primary care PBRNs in the State of Michigan. Henry C. Barry, M.D. $99,404.

- Morehouse School of Medicine, Atlanta, GA. The Southeast Regional Clinicians' Network is composed of health care professionals working in 142 federally funded community health centers in eight Southern States. George S. Rust, M.D., M.P.H. $89,335.

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Primary care practice-based research networks

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- Mount Sinai School of Medicine, New York, NY. The Mount Sinai Primary Care Practice-Based Research Network will combine the resources of academic department practices with community health centers serving the East Harlem and Central Harlem areas of New York City. Albert L. Siu, M.D., M.P.H. $125,650.

- University of California, San Diego, CA. The San Diego Unified Family Medicine Research Network is an emerging network that focuses on the primary care of underserved populations in southern California. Theodore G. Ganiats, M.D. $112,337.

- University of California, San Francisco, CA. The Collaborative Research Network, established in 1984 by the UCSF Department of Family and Community Medicine, will merge with the Community Health Network and Community Clinic Consortium of San Francisco to improve access to a large underserved urban patient population. Mary S. Croughan-Minihane, Ph.D. $132,750.

- University of Colorado Health Sciences Center, Denver, CO. The Colorado Research Network is focusing on health issues among underinsured and Hispanic people. Wilson D. Pace, M.D. $113,097.

- University of Kansas, Wichita, KS. The Kansas Rural Practice Research Network is a new collaboration of the University of Kansas School of Medicine, the Great Plains Health Alliance, the Kansas Academy of Family Physicians, and the Kansas chapter of the American College of Physicians. The network will include practices located in medically underserved communities of less than 3,000 population in rural Kansas. Ken Kallail, Ph.D. $112,374.

- University of Oklahoma, Oklahoma City, OK. The Oklahoma Physicians Resource/Research Network is a 6-year-old network of family physicians affiliated with the Oklahoma Academy of Family Physicians. The network plans to establish a collaborative relationship with the Oklahoma Native American Prevention Research Center. James W. Mold, M.D., M.P.H. $92,868.

- University of New Mexico, Albuquerque, NM. The New Mexico Practice Based Resource and Research Network is an emerging network consisting of clinicians in community health centers, Indian Health Service sites, tribal health care facilities, and academic primary care sites whose major purpose is to study racial and ethnic disparities in health. The planning grant for this project is being funded in part by the U.S. Indian Health Service. Robert L. Williams, M.D., M.P.H. $107,827.

- Virginia Commonwealth University, Richmond, VA. The Virginia Ambulatory Care Outcomes Research Network is a developing network of primary care practices in Virginia that collects longitudinal data on the health status of primary care patients. Steven H. Woolf, M.D., M.P.H. $93,287.

- Yale University School of Nursing, New Haven, CT. This network is composed of primary care advanced practice nurses who care for underserved populations in Southern New England. Margaret Grey, Ph.D., BSN. $111,919. ■

AHRQ awards new grants

The Agency for Healthcare Research and Quality (AHRQ) has awarded new research, conference, and training grants, including approximately $12 million in total projected funding over the next 5 years to fund 10 new research projects on key topics. These topics include pediatric and women's health, cost-effectiveness analysis, ethics in intensive care units, and smoking cessation. These projects are described below, followed by a listing of other research grants, small project grants, conference grants, and a National Research Service Award fellowship.

Readers are reminded that findings usually are not available until a project ends or is nearing completion. The newly funded projects are:

Improving the evidence for unstable angina guidelines. Principal investigator David A. Katz, M.D., University of Wisconsin, Madison. Total projected funding $87,917, project period 9/1/00–8/31/02. This project will assess the impact of AHRQ's unstable angina guideline on the outcomes of emergency room patients with chest pain.

Risk-adjustment of 1-year health status outcomes in coronary artery disease. Principal investigator John A. Spertus, M.D., M.P.H., Saint Luke's Foundation, Kansas City, MO. Total projected funding $1,294,396, funding period 9/1/00–8/31/04. This observational study will follow over 3,000 patients with acute coronary syndromes to identify their long-term outcomes, including physical and mental functioning, amount of angina, and quality of life for 1 year after hospital admission. This information will permit improved assessment of quality of care and facilitate patient decisionmaking by improving the understanding of anticipated outcomes.

Impact of early discharge following bypass surgery. Principal investigator Patricia A. Cowper, Ph.D., Duke University Medical Center, Durham, NC. Total projected funding $694,334. Project period 9/11/00–8/31/02. The objective of this study is to determine the impact of decreases in lengths of stay following coronary artery bypass graft surgery on clinical outcomes. Also, researchers will identify patient and hospital factors that are associated with good outcomes following early discharge.

Measurement of women's satisfaction with primary care. Principal investigator Carol S. Weisman, Ph.D., University of Michigan, Ann Arbor. Total projected funding $551,588. Project period 7/1/00–12/31/01. The goal of this project is to measure women's satisfaction with their primary health care. Researchers from three of the Department of Health and Human Services–designated National Centers of Excellence in Women's Health will develop a patient satisfaction instrument specific to women that can be used as a stand-alone tool or as a supplement to standard patient satisfaction instruments.

Statistical inference for cost-effectiveness analysis. Principal investigator Joseph Gardiner, Ph.D., Michigan State University, East Lansing. Total projected funding $793,419. Project period 7/1/00–6/30/03. The goal of this study is to develop statistical techniques to fill methodological gaps in current cost-effectiveness analysis models. The specific aims of the project are to develop new statistical approaches for estimates of cost-effectiveness parameters, conduct computer simulated studies to assess the performance of the proposed methods, and apply the proposed methods to actual data sets.

Care management by a nurse practitioner/hospitalist team. Principal investigator Marie J. Cowan, Ph.D., University of California, Los Angeles. Total projected funding $2,229,554. Project period 7/1/00–6/30/03. The researchers will test an intensive intervention using hospitalists collaborating with nurse practitioners who also engage in postdischarge followup with patients in a general medical unit of an academic medical center. This project is cofunded by AHRQ and the National Institute of Nursing Research.

Impact of ethics consultation in the intensive care unit. Principal investigator Lawrence J. Schneiderman, M.D., University of California, San Diego. Total projected funding $1,775,383. Project period 9/1/00–8/31/03. This multicenter, randomized controlled trial will examine the impact of ethics consultation for patients in intensive care units who

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New grants

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have been identified as having "value-based treatment conflicts."

Smoking control in maternal and child health clinics: Dissemination strategies. Principal investigator Clara Manfredi, Ph.D., University of Illinois, Chicago. Total projected funding $1,841,176. Project period 9/1/00–8/31/03. This study will evaluate two strategies to disseminate the "It's Time" smoking cessation program and the AHRQ smoking cessation guideline to maternal and child health public health clinics. Two Illinois public health and human services agencies will serve as influential intermediaries for the dissemination.

Pediatric evidence-based medicine: Getting evidence Used at the point of care. Principal investigator Robert L. Davis, M.D., M.P.H., University of Washington, Seattle. Total projected funding $1,007,940. Project period 9/1/00–8/31/03. This project will evaluate the use of evidence at the point of pediatric care. The goal is to increase the application of evidence-based medicine, change physician behavior, and expedite the translation of research into clinical practice. The study will include a series of randomized controlled trials implemented at three sites, including academic pediatric and family medicine health care centers and a rural pediatric clinic.

Home screening for chlamydia surveillance. Principal investigator Roberta B. Ness, M.D., University of Pittsburgh, Pittsburgh, PA. Total projected funding $1,696,066. Project period 7/25/00–6/30/05. The purpose of this randomized trial is to evaluate the effectiveness of home screening for two STDs–chlamydia and gonorrhea–relative to office-based screening among women with a prior diagnosis of chlamydia.

Other newly funded projects include the following:

Research Projects

Access and quality of care for vulnerable black populations

Project director:	Robert Mayberry, Ph.D.
Organization:	Morehouse School of Medicine Atlanta, GA
Project number:	AHRQ grant HS10875
Project period:	9/15/00 to 8/31/05
First year funding:	$425,645

Characterizing medical error: A primary care study

Project director:	Steven H. Woolf, M.D.
Organization:	Virginia Commonwealth University Richmond, VA
Project number:	AHRQ grant HS11117
Project period:	9/15/00 to 8/31/02
First year funding:	$177,912

Clinical prediction rule for pelvic fracture hemorrhage

Project director:	Christopher Blackmore, M.D., Ph.D.
Organization:	University of Washington Seattle, WA
Project number:	AHRQ grant HS11291
Project period:	9/15/00 to 8/31/05
First year funding:	$125,577

Computer-based guidelines to prevent sudden cardiac death

Project director:	Gillian Sanders, Ph.D.
Organization:	Stanford University Stanford, CA
Project number:	AHRQ grant HS10623
Project period:	9/30/00 to 8/31/03
First year funding:	$325,367

Consequences of drug cost-sharing in the elderly

Project director:	Sebastian Schneeweiss, M.D.
Organization:	Brigham and Women's Hospital Boston, MA
Project number:	AHRQ grant HS10881
Project period:	9/30/00 to 2/28/03
First year funding:	$454,687

Cost and benefits of intervening: Battered women

Project director:	Laura McCloskey, Ph.D.
Organization:	Harvard School of Public Health Boston, MA
Project number:	AHRQ grant HS11088
Project period:	9/30/00 to 8/31/05
First year funding:	$292,208

Developing an asthma management model for Head Start

Project director:	Perla A. Vargas, Ph.D.
Organization:	Arkansas Children's Hospital Little Rock, AR
Project number:	AHRQ grant HS11062

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New grants

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Project period: 9/26/00 to 8/31/03
First year funding: $426,245

Developing and validating quality measures for children
Project director: Mark R. Chassin, M.D.
Organization: Mount Sinai School of Medicine
New York, NY
Project number: AHRQ grant HS10302
Project period: 9/30/00 to 8/31/04
First year funding: $252,322

Effect of Navajo interpreters on diabetes outcomes
Project director: Melvina McCabe, M.D.
Organization: University of New Mexico
Albuquerque, NM
Project number: AHRQ grant HS10637
Project period: 9/30/00 to 9/29/05
First year funding: $483,565

Efficacy/reliability of telemedicine in routine pediatric practice
Project director: Kenneth McConnochie, M.D.
Organization: University of Rochester
Rochester, NY
Project number: AHRQ grant HS10753
Project period: 9/30/00 to 9/29/01
First year funding: $295,125

Empiric risk stratification rule for heart failure
Project director: Donald M. Yealy, M.D.
Organization: University of Pittsburgh
Pittsburgh, PA
Project number: AHRQ grant HS10888
Project period: 9/30/00 to 9/29/02
First year funding: $185,263

Health care markets and vulnerable populations
Project director: Jose J. Escarce, M.D., Ph.D.
Organization: RAND Corporation
Santa Monica, CA
Project number: AHRQ grant HS10770
Project period: 7/01/00 to 6/30/05
First year funding: $452,282

Health disparities in minority adult Americans
Project director: Edmund M. Ricci, Ph.D.
Organization: University of Pittsburgh
Pittsburgh, PA
Project number: AHRQ grant HS10864
Project period: 9/25/00 to 8/31/05
First year funding: $334,644

Helping elders include quality in health plan choice
Project director: Lauren Harris-Kojetin, Ph.D.
Organization: Research Triangle Institute
Research Triangle Park, NC
Project number: AHRQ grant HS11008
Project period: 9/30/00 to 8/31/03
First year funding: $320,010

Implementing adolescent preventive guidelines
Project director: Charles E. Irwin, M.D.
Organization: University of California
San Francisco, CA
Project number: AHRQ grant HS11095
Project period: 9/30/00 to 8/31/03
First year funding: $544,645

Improving pain management in nursing homes
Project director: Katherine Jones, Ph.D.
Organization: University of Colorado
Denver, CO
Project number: AHRQ grant HS11093
Project period: 9/27/00 to 8/31/03
First year funding: $583,838

Improving dispute resolution in health care
Project director: David M. Studdert, Sc.D.
Organization: Harvard School of Public Health
Boston, MA
Project number: AHRQ grant HS11285
Project period: 9/30/00 to 8/31/04
First year funding: $80,688

Improving quality with outpatient decision support
Project director: David W. Bates, M.D.
Organization: Brigham and Women's Hospital
Boston, MA
Project number: AHRQ grant HS11046
Project period: 9/30/00 to 8/31/03
First year funding: $469,996

Improving safety by computerizing outpatient prescribing
Project director: David W. Bates, M.D.
Organization: Brigham and Women's Hospital
Boston, MA
Project number: AHRQ grant HS11169
Project period: 9/30/00 to 8/31/03
First year funding: $533,379

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New grants

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Improving utilization of ischemic stroke research
Project director: Catherine Borbas, Ph.D.
Organization: Minneapolis Medical Research Foundation Minneapolis, MN
Project number: AHRQ grant HS11073
Project period: 9/30/00 to 8/31/03
First year funding: $452,738

Information about quality in a randomized evaluation
Project director: Patrick S. Romano, M.D.
Organization: University of California Davis, CA
Project number: AHRQ grant HS10985
Project period: 9/30/00 to 8/31/03
First year funding: $297,750

Insuring uninsured children
Project director: Glenn Flores, M.D.
Organization: Boston Medical Center Boston, MA
Project number: AHRQ grant HS11305
Project period: 9/18/00 to 8/31/05
First year funding: $99,819

Internet intervention to increase chlamydia screening
Project director: Jeroan J. Allison, M.D.
Organization: University of Alabama Birmingham, AL
Project number: AHRQ grant HS11124
Project period: 9/30/00 to 9/29/03
First year funding: $395,530

Managed care and health care markets
Project director: Laurence Baker, M.D., Ph.D.
Organization: Stanford University Stanford, CA
Project number: AHRQ grant HS10925
Project period: 9/30/00 to 9/29/03
First year funding: $450,000

Medicare managed care: Selection/ competition/quality
Project director: Glenn A. Melnick, Ph.D.
Organization: RAND Corporation Santa Monica, CA
Project number: AHRQ grant HS10256
Project period: 9/30/00 to 8/31/03
First year funding: $118,948

Observational studies vs. randomized controlled trials
Project director: Arthur Hartz, M.D., Ph.D.
Organization: University of Iowa Iowa City, IA
Project number: AHRQ grant HS10739
Project period: 9/30/00 to 8/31/02
First year funding: $198,063

Outcomes for intimate partner violence
Project director: Michael Rodriguez, M.D.
Organization: University of California San Francisco, CA
Project number: AHRQ grant HS11104
Project period: 9/30/00 to 9/29/04
First year funding: $248,315

Optimizing antibiotic use in long-term care
Project director: Mark B. Loeb, M.D.
Organization: McMaster University Hamilton, Ontario, Canada
Project number: AHRQ grant HS11113
Project period: 9/30/00 to 8/31/02
First year funding: $103,366

Overcoming racial health disparities
Project director: Timothy S. Carey, M.D.
Organization: University of North Carolina Chapel Hill, NC
Project number: AHRQ grant HS10861
Project period: 9/15/00 to 8/31/05
First year funding: $334,644

Patient-centered care and health care costs
Project director: Ronald M. Epstein, M.D.
Organization: University of Rochester Rochester, NY
Project number: AHRQ grant HS10610
Project period: 9/30/00 to 8/31/03
First year funding: $450,414

RCT of computer screening for domestic violence
Project director: Wendy Levinson, M.D.
Organization: University of Chicago Chicago, IL
Project number: AHRQ grant HS11096
Project period: 9/30/00 to 8/31/03
First year funding: $328,346

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New grants

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Resident assessment of pain management
Project director: Joan M. Teno, M.D.
Organization: Brown University
Providence, RI
Project number: AHRQ grant HS10336
Project period: 9/30/00 to 8/31/02
First year funding: $373,227

Rural emergency departments as access points for teen smoking intervention
Project director: Kimberly A. Horn, Ed.D.
Organization: West Virginia University
Morgantown, WV
Project number: AHRQ grant HS10736
Project period: 9/30/00 to 8/31/04
First year funding: $340,069

Teamwork and error in neonatal intensive care
Project director: Eric J. Thomas, M.D.
Organization: University of Texas Medical School
Houston, TX
Project number: AHRQ grant HS11164
Project period: 9/30/00 to 8/31/02
First year funding: $371,132

TIPI systems to reduce errors in emergency cardiac care
Project director: Harry P. Selker, M.D.
Organization: New England Medical Center
Boston, MA
Project number: AHRQ grant HS11200
Project period: 9/01/00 to 8/29/03
First year funding: $466,859

Translating prevention research into practice
Project director: Robert A. Levine, M.D.
Organization: Meharry Medical College
Nashville, TN
Project number: AHRQ grant HS11131
Project period: 9/30/00 to 9/29/03
First year funding: $643,021

Translating research: Patient decision support/coaching
Project director: Margaret Holmes-Rovner, Ph.D.
Organization: Michigan State University
East Lansing, MI
Project number: AHRQ grant HS10531
Project period: 9/30/00 to 11/30/03
First year funding: $615,476

Treatment outcomes for abused women in public clinics
Project director: Janet Y. Groff, M.D., Ph.D.
Organization: University of Texas
Houston, TX
Project number: AHRQ grant HS11079
Project period: 9/30/00 to 8/31/04
First year funding: $473,552

Understanding and eliminating health disparities in blacks
Project director: Barbara Tilley, Ph.D.
Organization: Medical University of South Carolina
Charleston, SC
Project number: AHRQ grant HS10871
Project period: 9/21/00 to 8/31/05
First year funding: $1,600,010

Understanding and reducing native elder health disparities
Project director: Spero M. Manson, Ph.D.
Organization: University of Colorado
Denver, CO
Project number: AHRQ grant HS10854
Project period: 9/30/00 to 9/29/05
First year funding: $1,195,840

Small Grants

Defining risks for chronic disease in spinal cord injury
Project director: Xin Wang, M.S.
Organization: University of Illinois
Chicago, IL
Grant number: AHRQ grant HS11277
Project period: 9/30/00 to 9/29/01
Funding: $32,215

Development and testing of an instrument to assess pain
Project director: Kandyce Richards, B.N., R.N.
Organization: University of Miami School of Nursing
Coral Gables, FL
Grant number: AHRQ Grant HS10788
Project period: 9/30/00 to 9/29/01
Funding: $29,989

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New grants

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Diagnosis of chest pain and care in rural hospitals
Project director: John Westfall, M.D.
Organization: University of Colorado
Denver, CO
Grant number: AHRQ grant HS11003
Project period: 9/30/00 to 9/29/01
Funding: $75,485

Effects of State home Medicare maximization plans
Project director: Wayne Anderson, M.D.
Organization: University of North Carolina
Chapel Hill, NC
Grant number: AHRQ grant HS11262
Project period: 9/30/00 to 9/29/01
Funding: $28,910

Efficiency improvements via monitoring in medical groups
Project director: N.M. Molinari, A.B.
Organization: Wayne State University
Detroit, MI
Grant number: AHRQ grant HS11275
Project period: 9/30/00 to 9/29/01
Funding: $32,400

Employees' responses to report cards about care systems
Project director: Jinnet B. Fowles, Ph.D.
Organization: Institute for
Research/Education
Minneapolis, MN
Grant number: AHRQ grant HS10823
Project period: 9/30/00 to 3/31/01
Funding: $61,037

Equating health measures: Testing the practical implications
Project director: Karon F. Cook, Ph.D.
Organization: Baylor College of Medicine
Houston, TX
Grant number: AHRQ grant HS11040
Project period: 9/30/00 to 9/29/02
Funding: $30,864

Evaluation of a guideline-based decision support system
Project director: David F. Lobach, M.D., Ph.D.
Organization: Duke University
Durham, NC
Grant number: AHRQ grant HS10814
Project period: 9/30/00 to 9/29/01
Funding: $77,000

Evaluating effectiveness of prenatal diabetes education in Pima Indians
Project director: Carolyn M. Smith, M.A.
Organization: University of Arizona
Tucson, AZ
Grant number: AHRQ grant HS10802
Project period: 9/30/00 to 2/28/02
Funding: $29,597

Evaluation of inappropriate psychotropic use in the elderly
Project director: Rajender R. Aparasu, Ph.D.
Organization: South Dakota State University
Brookings, SD
Grant number: AHRQ grant HS10813
Project period: 9/01/00 to 2/28/02
Funding: $66,512

Expectation measurement for persons with hip replacement
Project director: Mary Milidonis, M.M.S.C., P.T.
Organization: Case Western Reserve
University
Cleveland, OH
Grant number: AHRQ grant HS11272
Project period: 9/30/00 to 9/29/01
Funding: $31,980

Factors associated with hospice utilization
Project director: Susan C. Miller, Ph.D.
Organization: Brown University
Providence, RI
Grant number: AHRQ grant HS11004
Project period: 9/30/00 to 9/29/01
Funding: $78,863

Family carers' response to home-tube-fed older adults
Project director: Heidi J. Silver, M.S.
Organization: Florida International
University
Miami, FL
Grant number: AHRQ grant HS11276
Project period: 9/15/00 to 9/14/01
Funding: $32,109

For-profit hospital ownership and Medicare spending
Project director: Elaine Silverman, M.D.
Organization: Dartmouth-Hitchcock Medical
Center
Hanover, NH

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New grants

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Grant number: AHRQ grant HS11012
Project period: 9/01/00 to 2/28/02
Funding: $79,500

Improving chronic disease health status and utilization
Project director: Jan L. Wallander, Ph.D.
Organization: University of Alabama
Birmingham, AL
Grant number: AHRQ grant HS10812
Project period: 9/30/00 to 9/29/01
Funding: $71,727

Integration and quality in health networks and systems
Project director: Shannon Mitchell, M.A., M.P.H.
Organization: University of California
Berkeley, CA
Grant number: AHRQ grant HS11271
Project period: 9/30/00 to 9/29/01
Funding: $31,929

Intimate partner violence and pregnancy in primary care
Project director: Meredith Silverstein, M.S.
Organization: University of Colorado
Denver, CO
Grant number: AHRQ grant HS11269
Project period: 9/30/00 to 9/29/01
Funding: $31,398

Lesbians' use of assisted reproductive technologies
Project director: Jacquelyne M. Luce, M.A.
Organization: York University
Toronto, Ontario, Canada
Grant number: AHRQ grant HS11266
Project period: 9/30/00 to 9/29/01
Funding: $27,673

Outcomes in spontaneous and iatrogenic multiple pregnancy
Project director: Anne M. Lynch, M.B.
Organization: Kaiser Foundation Research Institute
Oakland, CA
Grant number: AHRQ grant HS10700
Project period: 9/30/00 to 12/31/01
Funding: $62,001

Outcomes of a managed care cost containment strategy
Project director: Mary E. Murray, Ph.D.
Organization: University of Wisconsin
Madison, WI
Grant number: AHRQ grant HS10667
Project period: 9/15/00 to 8/31/02
Funding: $39,217

Patient-defined culturally sensitive health care
Project director: Carolyn M. Tucker, Ph.D.
Organization: University of Florida
Gainesville, FL
Grant number: AHRQ grant HS10726
Project period: 9/30/00 to 9/29/01
Funding: $71,341

PEAT: Pediatric emergency assessment tool
Project director: Marc Gorelick, M.D.
Organization: Medical College of Wisconsin
Milwaukee, WI
Grant number: AHRQ grant HS11395
Project period: 9/30/00 to 9/29/02
Funding: $38,462

Perinatal health services research
Project director: Douglas Richardson, M.D.
Organization: Beth Israel Deaconess Medical Center
Boston, MA
Grant number: AHRQ grant HS10824
Project period: 9/30/00 to 9/29/01
Funding: $62,411

Prescription patterns and practice for postmenopausal therapy
Project director: Jennifer Miglionico, M.S.
Organization: Dartmouth College
Hanover, NH
Grant number: AHRQ grant HS10789
Project period: 9/30/00 to 9/29/01
Funding: $32,158

Respiratory isolation for tuberculosis
Project director: Juan P. Wisnivesky, M.D.
Organization: Mount Sinai School of Medicine
New York, NY
Grant number: AHRQ grant HS11393
Project period: 9/30/00 to 9/29/01
Funding: $84,750

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New grants

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Risk selection and Medicare HMOs
Project director: Jason D. Brown, B.A.
Organization: Stanford University
Stanford, CA
Grant number: AHRQ grant HS11268
Project period: 9/30/00 to 9/29/01
Funding: $28,054

Spouse involvement in cardiac patients' behavior change
Project director: Tantina B. Hong, M.A.
Organization: Wayne State University
Detroit, MI
Grant number: AHRQ grant HS11263
Project period: 9/30/00 to 9/29/01
Funding: $31,016

Time to neonatal and postneonatal death in the United States, 1985-1995
Project director: Amanda J. Liddle, M.P.H.
Organization: University of Alabama
Birmingham, AL
Grant number: AHRQ grant HS11259
Project period: 9/30/00 to 9/29/01
Funding: $32,400

Women's expectation of postpartum care in the first week after birth
Project director: Christa Kelleher, B.A.
Organization: Brandeis University
Waltham, MA
Grant number: AHRQ grant HS10790
Project period: 9/30/00 to 2/28/02
Funding: $22,152

Conference Grants

Accelerating change today for America's health
Project director: Henry E. Simmons, M.D.
Organization: National Coalition on Health Care
Washington, DC
Grant number: AHRQ grant HS10754
Project period: 9/30/00 to 8/31/02
Funding: $319,558

Small grant program for conference support
Project director: Charles Bennett, M.D., Ph.D.
Organization: Northwestern University
Evanston, IL
Grant number: AHRQ grant HS10933
Project period: 9/30/00 to 9/29/01
Funding: $20,000

Small grant program for conference support
Project director: Michael Dale Hagen, M.D.
Organization: University of Kentucky
Lexington, KY
Grant number: AHRQ grant HS10931
Project period: 9/15/00 to 9/14/01
Funding: $20,252

Research to practice conference
Project director: Naomi J. Kuznets, Ph.D.
Organization: AAAHC Institute for Quality Improvement
Wilmette, IL
Grant number: AHRQ grant HS10934
Project period: 9/30/00 to 9/29/01
Funding: $39,929

Techniques for handling bias in health services research
Project director: Kimberly J. Wristers, Ph.D.
Organization: Baylor College of Medicine
Houston, TX
Grant number: AHRQ grant HS10935
Project period: 9/30/00 to 8/31/01
Funding: $19,999

National Research Service Award

Utilization of mental health services by Asian-Pacific Islander Americans
Fellow: Jinah K. Shin, D.N.S.C.
Organization: Columbia University School of Medicine
New York, NY
Grant number: NRSA fellowship F32 HS00149; Kristine M. Gebbie, sponsor
Project period: 1-year fellowship
Funding: $32,416 ■

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 description of the project. See the back cover of *Research Activities* for ordering information.

Deploying Idealized Design of Clinical Office Practices. **Charles M. Kilo, M.D., M.P.H., Institute for Healthcare Improvement, Boston, MA. AHRQ grant HS10093, project period 2/18/00-2/17/01.**

This report describes a conference held March 1, 2000, that brought together 27 leaders from the American Academy of Family Physicians, the American Academy of Pediatrics, and the American Academy of Neurology and others. Participants discussed resources within the academies, developed academy-specific strategies to enhance dissemination of the Idealized Design of Clinical Office Practice (IDCOP) initiative, and drafted action plans for future work. The goal IDCOP is to demonstrate that clinical office practices, with appropriate redesign, can achieve significant improvement in performance relevant to today's urgent social needs. (Abstract, executive summary, and final report, NTIS accession number PB2000-107480; 16 pp, $23.00 paper, $12.00 microfiche)***

Evaluation of a Home- and Community-based Waiver for Persons with AIDS. **Jean M. Mitchell, Ph.D., Georgetown University, Washington, DC. AHRQ grant HS09560, project period 9/30/97-9/29/99.**

The researchers analyzed Florida Medicaid claims data for people with AIDS from December 1993 through December 1997 to determine how participation in the home- and community-based waiver program (providing home- and community-based services in lieu of more expensive hospital-based care) affected the use of services, monthly expenditures, and survival rates. Monthly expenditures were almost $843 or 42 percent higher for nonparticipants compared with participants, and these differences persisted across demographic groups. An analysis of 1996-1997 data—a period during which combination drug therapy was available for Medicaid patients with HIV or AIDS–revealed that the selection of the waiver was not random. White men and sicker patients were more likely to participate in the waiver than other groups. Also, compared with nonparticipants, waiver participants were more likely to receive combination therapy and less likely to use inpatient care, have monthly Medicaid expenditures that were 49 percent lower, and have similar survival rates. Overall, the study concludes that the Florida Medicaid AIDS waiver (Project AIDS Care) appears to be an efficient treatment option. (Abstract, executive summary, and final report, NTIS accession number PB2000-107823; 30 pp, $23.00 paper, $12.00 microfiche)***

Impact of Infant Feeding Method on Health Services Costs and Utilization in a Medicaid Population. **Aylin A. Riedel, University of Minnesota, Minneapolis. AHRQ grant HS10163, project period 7/1/99-6/30/00.**

The researcher examined the relationship between the method of infant feeding (breast or formula) and health care costs and utilization among 1,374 infants enrolled in Medicaid in Colorado. Data sources included Medicaid claims for the first 12 months of the infants' lives, linked to vital statistics and WIC files. The researcher suggests that the infant feeding–health status relationship is confounded by several factors related to both the choice of feeding method and to infant health outcomes, including maternal income, education, age, marital status, and smoking status. Analysis of outpatient costs and utilization initially indicated that breastfeeding led to lower costs and utilization, even after controlling for demographic factors. However, after identification and removal from the data set of infants with preexisting illnesses, the impact of breastfeeding on health care costs and utilization disappeared. The author attributes this to the fact that infants with preexisting illnesses or more severe conditions were more likely to be placed on formula, even when breastfeeding was not contraindicated. (Abstract and executive summary, NTIS accession number PB2000-107824; 18 pp, $23.00 paper, $12.00 microfiche)***

Improve – Improving Disease Prevention in Primary Care. **Leif I. Solberg, M.D., Group Health Foundation, Minneapolis, MN. AHRQ grant HS08091, project period 7/1/93-6/30/98.**

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Grant final reports

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The researchers examined whether an intervention emphasizing preventive services and the use of continuous quality improvement (CQI) techniques could stimulate the private primary care clinics of a managed care organization to develop and maintain systems to routinely deliver clinical preventive services. A randomized, controlled trial of an intervention, with baseline and followup measures of delivery of selected preventive services, was conducted in 44 primary care clinics affiliated with two HMOs in the Minneapolis-St. Paul area; eight preventive services were measured by patient report and chart audit in two cross-sections of visiting patients (more than 6,000 patients surveyed at baseline and followup, with about 4,600 chart audits in each group). In the clinics randomly assigned to the intervention, two of the eight preventive services increased by modest, but statistically significant, amounts. None of the other service delivery rates increased significantly, leading the researchers to conclude that CQI techniques as used in this trial failed to have a significant effect on the delivery of preventive services. (Abstract and executive summary, NTIS accession number PB2000-107822; 16 pp, $23.00 paper, $12.00 microfiche)***

Models of Integrated Long-Term Care: Rural Applications. **Joyce E. Beaulieu, M.P.H., Ph.D., University of Kentucky, Lexington. AHRQ grant HS09850, project period 5/1/99-4/30/00.**

This 2-day conference on integrated models of long-term care in rural areas was convened by the University of Kentucky Center for Health Services Management and Research, the Sanders-Brown Center on Aging, and the Rural Center. The purpose of the conference was to discuss current research in models that integrate payers, providers, and clients; current models being implemented; and how integrated rural programs can be implemented. An agenda for further research was developed, identifying the need for more information on the effectiveness of case-management models, contracts, and gatekeeping arrangements for rural providers and research on innovations in training and recruitment for rural nursing home staff. (Abstract, executive summary, and final report, NTIS accession number PB2000-107459; 24 pp, $23.00 paper, $12.00 microfiche)***

Outcomes Dissemination: The Maine Study Group Model. **Robert B. Keller, M.D., Maine Medical Assessment Foundation, Manchester. AHRQ grant HS06813, project period 9/30/91-3/31/97.**

This project involved the export of the Maine physician study group model of quality improvement to both New Hampshire and Vermont, establishing a tri-State study group initiative. The principal objectives of the 5-year project were to demonstrate the effectiveness of the specialty-oriented study group and data feedback methodology in producing changes in physician behavior; to determine, via survey research, the effect of the data feedback process on physician knowledge and attitudes; and to demonstrate that the feedback approach can be used to disseminate research findings and other clinical information. An evaluation of the program concluded that the physician study group model can be replicated in other areas in a relatively short period of time, and that physicians new to the process broadly accepted both the models and the process goals. (Abstract, executive summary, and final report, NTIS accession number PB2000-107480; 100 pp, $29.50 paper, $17.00 microfiche)***

Outcomes Following Minor Head and Abdominal Trauma. **David H. Livingston, M.D. University of Medicine and Dentistry of New Jersey, Newark. AHRQ grant HS07336, project period 8/1/94-7/31/98.**

The goals of this study were to evaluate the current practice of mandatory hospitalization for observation only following two specific types of injury, minimal head injury (MHI) and minor abdominal trauma, and to develop practice guidelines that could reliably rule out significant injuries without hospitalization. The researchers evaluated 2,500 trauma patients admitted to level-one trauma centers. All patients underwent a physical examination followed by cranial or abdominal computed tomographic (CT) scanning. Patients were then admitted to the hospital and observed for the development of missed injuries. For both MHI and minor abdominal trauma, no single or combination of findings upon physical examination could predict an injury observed with CT scanning. Scanning of the cranium or abdomen had a high negative predictive value. The researchers conclude that it is safe to discharge patients who show no sign of intracranial or intra-abdominal injuries upon CT scanning, obtained on a helical or spiral CT scanner, without a period of either inpatient or outpatient observation. (Abstract, executive summary, and final report, NTIS accession

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number PB2000-107821; 62 pp, $27.00 paper, $12.00 microfiche)***

Pharmacists as Adult Immunizers: Effects on Sites and Rates of Vaccine Delivery. **John D. Grabenstein, R.Ph., Ph.D., University of North Carolina, Chapel Hill. AHRQ grant HS10021, project period 9/30/98-9/29/00.**

This study involved a cross-sectional survey of 1,730 adults vaccinated by pharmacists at 21 pharmacies in 10 States. More than 96 percent of the respondents were fully satisfied. Many of those vaccinated considered pharmacists advantageous for access, proximity, trust, convenience, and cost. Another component of the study contrasted influenza vaccination patterns among adult prescription recipients in urban Washington State, where pharmacists administer vaccines, and urban Oregon, where they do not. Influenza vaccination rates were 7 percent higher in Washington State than in Oregon in 1998, adjusting for baseline (1997) differences. (Abstract and executive summary, NTIS accession number PB2000-107479; 16 pp, $23.00 paper, $12.00 microfiche)***

Prevention and Competing Demands in Primary Care. **Benjamin J. Crabtree, Ph.D., University of Nebraska Medical Center, Omaha. AHRQ grant HS08776, project period 9/30/96-9/29/99.**

The goal of this study was to determine why otherwise effective approaches to quality improvement often fail to bring about change when implemented in primary care practices. Eighteen in-depth case studies were conducted in a diverse sample of Midwestern family practices to examine organizational contexts that enhance or inhibit delivery of preventives services and efforts to change. These practices had a common set of activities, such as charting, billing, and patient care, but approaches to accomplish these activities had emerged individually over time and were shaped by distinct external and internal stimuli. Assessment and intervention processes developed during this study can be used to tailor interventions to bring about change in diverse practice settings. (Abstract, executive summary, and final report, NTIS accession number PB2000-107457; 60 pp, $27.00 paper, $12.00 microfiche)***

Primary Care Physician Participation in Managed Care. **Andrew B. Bindman, M.D., University of California, San Francisco. AHRQ grant HS09557, project period 9/30/97-9/29/98.**

A longitudinal survey was mailed in 1996 and again in 1998 to 713 general internists, family physicians, pediatricians, and obstetricians-gynecologists in 13 urban California counties to determine whether the expansion of Medicaid managed care was associated with a change in the number and characteristics of primary care physicians treating Medicaid and uninsured patients. The survey revealed no statistically significant change in the percentage of the physicians seeing Medicaid patients in their practices. There was, however, a slight decrease in the percentage of physicians accepting new Medicaid patients and a larger decrease in the percentage of these physicians who had uninsured patients in their practices. The findings suggest that expansion of Medicaid did not improve access to primary care physicians for California's Medicaid beneficiaries or the uninsured. (Abstract, executive summary, and final report, NTIS accession number PB2000-107458; 32 pp, $25.50 paper, $12.00 microfiche)***

Risk and Risk Factor Modeling Project. **Louise B. Russell, Ph.D., Rutgers University, New Brunswick, NJ. AHRQ grant HS07002, project period 2/1/92-1/31/95.**

This project produced a comprehensive model of the risks of death, hospitalization, and nursing home admission as a function of a common set of biomedical and behavioral risk factors. The relationships on which the model is based were estimated with data from a nationally representative sample of noninstitutionalized U.S. adults, the Epidemic Follow-up Study (NHEFS) of the National Health and Nutrition Examination Study (NHANES I). The model can be used to project the health effects of risk-factor modification over a 20-year period in a common framework which assures that comparisons across interventions are valid. It is particularly appropriate for studies of the effectiveness and cost-effectiveness of preventive interventions. (Abstract, executive summary, and final report, NTIS accession number PB2000-108004; 284 pp, $56.00 paper, $23.00 microfiche)***

Symposium on Evidence-Based Practice of Oncology. **Benjamin M. Djulbegovic, M.D., University of South Florida, Tampa. AHRQ**

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grant HS10075, project period 8/1/99-7/31/00.

This symposium was organized to teach skills for the practice of evidence-based oncology and to present the strengths and weaknesses of the available body of evidence for the most common disorders in oncology. (Final report, NTIS accession number PB2000-107861; 11 pp, $23.00 paper, $12.00 microfiche)***

Utah Usage of EMS Services by Children. **Anthony J. Suruda, M.P.H., University of Utah, Salt Lake City. AHRQ grant HS09057, project period 9/1/95-11/30/99.**

This study examined how Utah children used emergency medical services (EMS) and related hospital care in 1991-92. The EMS and hospital records were linked using special software. Ambulance and hospital charges for children were estimated to be $35 million, not counting physician charges, prescriptions, and rehabilitation care. The principal findings of the study concerned the care of children younger than 5 years of age. These children received fewer procedures prior to being transported to a hospital and required more time at the scene for assessment. Some interventions, such as splinting of fractured arms prior to transport to a hospital, were related to reduced hospital charges. A training program for ambulance personnel in intravenous (IV) line placement resulted in a reduction in the amount of time EMS personnel spent at the scene. (Abstract, executive summary, and final report, NTIS accession number PB2000-107454; 66 pp, $27.00 paper, $12.00 microfiche)*** ■

Pharmaceutical outcomes research conference planned for spring 2001

The Drug Information Association will hold a 3-day conference on pharmaceutical outcomes research in the spring in Savannah, GA. The meeting will be held April 22-24, 2001 at the Savannah Marriott Riverfront, in Savannah, GA. The meeting will give participants an opportunity to learn about new and exciting findings from outcomes research on the use of drugs and biologics. New initiatives in patient safety will be discussed, and representatives from the Agency for Healthcare Research and Quality and the Food and Drug Administration will be on hand to provide updates on their agencies' activities. Also, the new patient safety initiatives will be discussed.

The conference will be of particular interest to outcomes researchers, purchasers of health care, and representatives of the pharmaceutical and managed care industries and clinical leadership organizations. Examples of conference topics include: changing prescriber behavior, the role of the pharmacist, the relationship between quality measures and outcomes, the dissemination and impact of guidelines, medication errors, pharmacoepidemiology, computerized reminders, and special populations and carve-outs. Many other topics are planned in the areas of patient self-management and adherence, adverse drug events, the health care delivery system, information technology, managed care, proactive surveillance/risk management, and outcomes research in progress.

On the Internet, go to http://events.diahome.org/event-detail.asp?EventID=01073 to get more information or register for this meeting. Or you may contact the DIA office at 215-591-3325 (fax 215-641-1229) or via e-mail to mcginnj@diahome.org if you have further questions. ■

Matchar, D.B., Samsa, G.P., Cohen, S.J., and Oddone, E.Z. (2000). "Community impact of anticoagulation services: Rationale and design of the Managing Anticoagulation Services Trial (MAST)." (AHRQ contract 290-91-0028). ***Journal of Thrombosis and Thrombolysis*** **9, S7-S11.**

Atrial fibrillation (AF) is a common cardiac rhythm disturbance, especially among older people, that increases the risk of stroke 5- to 6-fold, compared with people who have normal heart rhythms. This article describes the design of a practice improvement trial testing whether anticoagulation services are a preferred way to manage anticoagulation to prevent stroke among patients with AF. Practice improvement trials such as the Managing Anticoagulation Services Trial (MAST) are effectiveness trials that examine the management of clinical problems in the context in which care is usually given. Noteworthy features of the MAST include defining the interventions in functional terms, which can empower site investigators to invent locally suitable systems, and collaboration with managed care organizations.

Nabors, L.A., Weist, M.D., and Reynolds, M.W. (2000, May). "Overcoming challenges in outcome evaluations of school mental health programs." (AHRQ grant HS09847). ***Journal of School Health*** **70(5), pp. 206-209.**

School mental health programs have grown and improved substantially in the last 20 years. However, evaluations of outcomes for children receiving these services are needed to provide accountability data and ensure the sustainability of these programs. Most outcome evaluations of school mental health programs are in their infancy and focus on examining the short-term impact of services on individuals. This focus probably should be expanded to explore both short-term and long-term effects of these programs in different schools and in various communities. Such studies eventually can determine exactly which treatments are related to positive changes for children with specific problems, such as phobias or depression. When designing these studies, evaluators must overcome several challenges that may threaten the validity of their conclusions. In this paper, the authors review these threats and suggest ways to overcome them. ■

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