

# A Bibliography of Selected RAND Publications

January 2002

SB-6027

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- WENGER, N.**  
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LRP-200105-15 Violence Exposure Among School-Age Children in Foster Care: Relationship to Distress Symptoms.
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MR-1419-DVA An Analysis of the Veterans Equitable Resource Allocation (VERA) System.

## ABSTRACTS

### MONOGRAPH/REPORTS

**MR-1018/1-OSD** A Review of the Scientific Literature as It Pertains to Gulf War Illnesses. Vol. 1, Infectious Diseases. L. H. Hilborne, B. A. Golomb. 2001.

Numerous Gulf War veterans have reported a range of illnesses and symptoms after serving in the Persian Gulf. Some of the reported symptoms are similar to those caused by diseases known to be prevalent in that region. This report discusses these infectious diseases and considers them as potential causes of the symptoms reported by the veterans. The authors present a short summary of etiology, diagnosis, and treatment for several infectious diseases and infectious organisms, including bacterial, viral, and parasitic infections. Two biological agents, anthrax and botulinum toxin, are also discussed.

**MR-1018/11-OSD** Psychological and Psychosocial Consequences of Combat and Deployment with Special Emphasis on the Gulf War. D. H. Marlowe. 2001.

Research in the neurosciences has demonstrated that the boundary between the external world (its events, pressures, concerns and stress) and the brain and body has been broken. The concept of anything being "all in the mind" is scientifically and intellectually dead. While some data remain ambiguous and direct causal effect cannot be given to "stress" per se, the overall patterns of research findings demonstrate that stress is a contributing factor to many illnesses, including somatic and psychological symptoms. Therefore, very real consequences attend those who experience prolonged subacute chronic stress, which characterized in the Gulf deployment, combat, and return home. It is feasible that the effects of these stresses made some soldiers more vulnerable to environmental pathogens, both in the theater and at home, than they would otherwise have been. The symptoms of such insults, nested in sociocultural beliefs about illness and the Gulf, might well have amplified deleterious somatic consequences. Like many illnesses, those pertaining to service in the Gulf have been culturally shaped. An illness narrative describes the causes of the illness as perceived by the patient and is most often constructed out of the assertions, metaphors, folklore, causal attributions, and adduced causes common in the patient's culture. Other agents of a presumed authorities, the Internet, and support and self-help groups. Such illness narratives can become an important factor in shaping both the nature and interpretation of symptoms by the patient. A cogent, widespread, and widely shared illness narrative is certainly a characteristic development of Gulf War illness. The threads of combat and deployment stress and the side

spectrum of possible responses, as demonstrated throughout history, weaves into the matrix of possible illness causation. It is also possible that a subset of the population is (in some ways, not yet understood) vulnerable and predisposed to injurious responses to the multiple stressors experienced in deployment and combat. This book argues that, to be most helpful to veterans, we must deal with this issue of complexity and not simply focus on a hypothesized or "hoped for" singular cause of Gulf War illness.

**MR-1206-SANOFI** Pharmaceutical Technology Assessment for Managed Care: Current Practice and Suggestions for Improvement. S. A. Bozzette, R. D'Amato, S. C. Morton, K. Harris, R. Meili, R. Taylor. 2001.

Powerful pharmaceuticals are of increasing clinical and economic importance to managed care organizations, which are often responsible for managing and paying for the increasing costs of pharmaceuticals. This creates an incentive for them to go beyond a focus on clinical effectiveness and safety to evaluate the cost-effectiveness of new drugs. This report describes the processes by which managed care organizations evaluate pharmaceutical technologies and suggests pathways for organizing improvement. It reviews current evaluation procedures, provides a framework for future evaluations, introduces evaluation approaches, and annotates resources for further research on each topic covered. The report finds that most managed care organizations have internal procedures for assessing new pharmaceutical technologies, but their medical directors commonly believe these procedures to be less rigorous and less systematic than are desirable. The decisionmaking framework outlined in the report and the techniques it incorporates describe an objective, reproducible process for assessing pharmaceutical technology in the managed care setting. It provides a "road map" that can help an organization expose hidden biases in current processes, build on its experiences with evaluation, and reduce the risk of illogical or poorly thought-through decisions.

**MR-1213-ADA** Self-Reported Behavior and Attitudes of Enrollees in Capitated and Fee-for-Service Dental Benefit Plans. I. D. Coulter, M. Marcus, J. Freed, C. Der-Martirosian, N. Guzman-Becerra, B. J. Genovese, D. P. Goldman. 2001.

Dental care is not immune to the wave of rising costs that has hit other sectors of the health care industry. In an effort to contain those costs, insurance providers have increasingly turned to capitation plans (CAP), which shift

the costs of care to the dentist, rather than fee-for-service plans (FFS), wherein costs are shifted to the patient. How do the two types of plans differ in terms of their effect on patient behavior and perceived level of care? This report gauges how people rate their plans and their oral health through a bivariate and multivariate analysis of the results of a survey submitted by 2,340 respondents; 57.7 percent of them in FFS plans and 42.3 in CAP plans. The authors analyzed several variables, including income, out-of-pocket-costs, and demographic categories, that gave rise to significant differences in perceptions of oral health, satisfaction with plan, and satisfaction with dentist. The authors conclude by noting that a general dissatisfaction exists with CAP plans as compared to FFS plans.

**MR-1267-A** Putting Practice Guidelines to Work in the Department of Defense Medical System: A Guide for Action. W. Nicholas, D. O. Farley, M. E. Vaiana, S. Cretin. 2001.

The challenges of implementing evidence-based practice guidelines in clinical settings have been widely recognized in the health care field. This implementation guide is designed as a "how-to" resource for managers and clinicians in the Military Health System who seek practical techniques to help them integrate evidence-based practice guidelines into the medical care processes at their medical treatment facilities (MTFs). The guide will be of particular use because its content is based on both published research on clinical guideline implementation and more than two years of experience with guideline implementation during the Army Medical Department/RAND Guideline Implementation project. In this project, three regional demonstrations tested methods for implementing three different guidelines, with the participation of eleven Army MTFs. Lessons learned from the project have been incorporated into the information provided in this guide as well as in field note examples highlighted throughout the document.

**MR-1269-DG/XII/RE** The RAND/UCLA Appropriateness Method User's Manual. K. Fitch, S. Bernstein, M. D. Aguilar, B. Burnand, J. R. LaCalle, P. Lazaro, M. van het Loo, J. McDonnell, J. Vader, J. P. Kahan. 2001.

Health systems should function in such a way that the amount of inappropriate care is minimized, while at the same time stinting as little as possible on appropriate and necessary care. The ability to determine and identify which care is overused and which is underused is essential to this functioning. To this end, the "RAND/UCLA Appropriateness Method" was developed in the 1980s. It has been further developed and refined in North America and, increasingly, in Europe. The rationale behind the method is that randomized clinical trials—the "gold standard" for evidence-based medicine—are generally

either not available or cannot provide evidence at a level of detail sufficient to apply to the wide range of patients seen in everyday clinical practice. Although robust scientific evidence about the benefits of many procedures is lacking, physicians must nonetheless make decisions every day about when to use them. Consequently, a method was developed that combined the best available scientific evidence with the collective judgment of experts to yield a statement regarding the appropriateness of performing a procedure at the level of patient-specific symptoms, medical history, and test results. This manual presents step-by-step guidelines for conceptualising, designing, and carrying out a study of the appropriateness of medical or surgical procedures (for either diagnosis or treatment) using the RAND/UCLA Appropriateness Method. The manual distills the experience of many researchers in North America and Europe and presents current (as of the year 2000) thinking on the subject. Although the manual is self-contained and complete, the authors do not recommend that those unfamiliar with the RAND/UCLA Appropriateness Method independently conduct an appropriateness study; instead, they suggest "seeing one" before "doing one." To this end, contact information is provided to assist potential users of the method.

**MR-1270-A** Army Medical Support to the Army After Next: Issues and Insights from the Medical Technology Workshop, 1999. G. Cecchine, D. Johnson, W. L. Perry, C. R. Anthony, B. A. Golomb, A. C. Hearn, L. H. Hilborne, J. M. Sollinger. 2001.

The Army Medical Department is planning now to ensure that the Army will have the required medical capabilities in 2025. As part of this planning, it conducted Medical Technology Workshop 1999 to investigate technologies for future medical concepts and capabilities. Besides gleaned insights from both the functional and technology perspectives into such areas medical informatics, combat service support, and biological and chemical defense, RAND analysts in this report identify areas warranting further investigation. The authors also discuss methods of improving future workshops.

**MR-1340-CSCR** The Effectiveness of Involuntary Outpatient Treatment: Empirical Evidence and the Experience of Eight States. M. S. Ridgely, R. Borum, J. Petrila. 2001.

Many states use civil commitment—a statutorily created and court-ordered form of compulsory treatment—to compel people with mental illness who become gravely disabled or dangerous to themselves or others to undergo treatment. In the last decade, many states have amended or interpreted their existing civil commitment statutes to allow for involuntary outpatient treatment. Such a law has been proposed for California. At the request of the

California State Senate, the authors conducted a systematic literature review on involuntary outpatient commitment; examined the experience of eight other states including statutory analysis and in-depth interviews with attorneys, public officials, and psychiatrists; and analyzed California administrative data for all persons served by California's county contract mental health agencies. They found that involuntary outpatient commitment, when combined with intensive mental health services, can be effective in reducing the risk of negative outcomes. But whether a court order in and of itself has any effect is an unanswered question. However, there is clear evidence that intensive community-based voluntary mental health treatment can produce good outcomes. There are no cost effectiveness studies that compare the relative return on investment in developing an involuntary outpatient treatment system or focusing all available resources on developing state-of-the-art treatment systems. Either approach would require a sustained commitment by California policymakers.

**MR-1347-DPRC** Prenatal Cocaine Exposure: Scientific Considerations and Policy Implications. S. L. Wenzel, B. E. Kosofsky, J. A. Harvey, M. Y. Iguchi, P. Steinberg, K. E. Watkins, R. Shaikh. 2001.

New research has shown that children exposed to cocaine before birth are at risk of learning and behavioral problems. Such problems have broad implications for education, social welfare, and criminal justice in the United States. However, there are numerous opportunities to minimize prenatal cocaine exposure and its impacts and thus to enhance the well-being of women and their children. This report, a collaborative effort of the RAND Drug Policy Research Center and the New York Academy of Sciences, presents an overview of the current state of knowledge regarding the effects of cocaine on the developing brain and offers policy considerations for addressing the issues that arise from cocaine use by pregnant women. The report discusses three prevention strategies: primary prevention (preventing substance use before and during pregnancy); secondary prevention (identifying pregnant women who use drugs and minimizing their drug use); and tertiary prevention (reducing the adverse consequences of substance exposure in children who were exposed in utero). In addition, the report presents a number of areas where more research is needed and offers a rationale for making more resources available for women and children affected by cocaine.

**MR-1352-OSD** Final Evaluation Report for Uniformed Services Family Health Plan Continuous Open Enrollment Demonstrations. M. Schoenbaum, K. Harris, G. Cecchine, M. Bradley, A. Suarez, T. Tanielian, C. R. Anthony. 2001.

The National Defense Authorization Act for Fiscal Year 2000 established the authority for a demonstration program under which eligible military retirees and their dependents would be permitted to enroll in the Uniformed Services Family Health Plan (USFHP) at any time, rather than during a designated 30-day period each spring. The USFHP Continuous Open Enrollment demonstration was conducted at three of the seven USFHP sites, beginning in early 2000. This book assesses the likely impact of continuous open enrollment on beneficiaries, the DoD, and other stakeholders. The authors interviewed USFHP and DoD staff and other key participants involved in rate-setting negotiations, visited each demonstration site, conducted focus groups with enrolled and eligible non-enrolled beneficiaries, and analyzed data on enrollment patterns. The evaluation found no apparent drawbacks for beneficiaries of the continuous open enrollment policy, nor any evidence that it increased enrollment in USFHP. For beneficiaries under age 65, the authors found that a de facto policy of continuous open enrollment already exists because beneficiaries may enroll in TRICARE Prime and then transfer to USFHP at any time. Finally, the authors expect the financial risk to the DoD to be minor, mainly because the current system of calculating payment rates places most risk from adverse selection on the USFHP. The authors recommend that the continuous open enrollment policy be extended to all USFHP sites and be made permanent.

**MR-1373-RE/CVZ** Combinatietherapie Bij Reumatoïde Artritis: Prioriteiten Voor Toekomstig Onderzoek. M. van het Loo, I. van Beusekom, P. W. G. Bots, R. Allaart, C. MacLean, F. C. Breedveld, J. P. Kahan. 2001.

It is not possible to conduct randomized clinical trials (RCTs) on all the many new health care options that arise. Screening of these options is necessary, based upon reducing uncertainty in the clinical community about their appropriateness. The RAND/UCLA Appropriateness Method extrapolates from scientific-based evidence to assess whether clinical procedures at the level of patient-based characteristics (indications) are (1) inappropriate; (2) uncertain; or (3) appropriate. The authors extended the method to assess the basis for judgment by asking for each indication whether appropriateness was based upon (A): strong direct evidence, (B) weaker or indirect evidence, (C) consensus methods, or (D) personal opinion. This double-rating can be cast into a priority matrix, a logical form for prioritizing RCTs. For the high and medium priorities, a rank-ordering of cells further prioritized the indications. This matrix was tested in a 12-member Dutch expert panel study of combination treatments for rheumatoid arthritis, using 17 treatment combinations for each of 16 patient indications (272 ratings), and yielded results regarded by the panelists as reasonable, valid, and

not entirely predictable. The authors concluded that expanded application of the RAND/UCLA Appropriateness Method can be used to prioritize the need for further research to provide evidence for clinical practice.

**MR-1396-RE/FOPH/DPRC** A Review of Recent Advances in Knowledge About Methadone Maintenance Treatment. I. van Beusekom, M. Y. Iguchi. 2001.

This report, which provides a knowledge base for the development of methadone maintenance treatment clinical guidelines in Switzerland, reviews the world-wide literature (except for Switzerland, which is the subject of a separate investigation) on such treatment and existing guidelines. Articles on methadone maintenance treatment and concurring treatment modalities are discussed in detail, as well as existing knowledge about specific populations, such as pregnant addicts and addicts with HIV or tuberculosis. Research on prognostic factors to patients' responses to treatment and perceptions of opiate dependent persons are also reviewed to ascertain their value to practitioners in managing methadone maintenance treatment and in assessing the best possible treatment. A final chapter describes other substitution treatments in comparison to methadone maintenance and synthesizes the information of the review into a structured information source for thinking about guideline development.

**MR-1419-DVA** An Analysis of the Veterans Equitable Resource Allocation (VERA) System. J. Wasserman, J. S. Ringel, B. Wynn, J. Zwanziger, K. Ricci, S. J. Carlson-Newberry, B. J. Genovese, M. Schoenbaum. 2001.

Since April 1997, the Veterans Equitable Resource Allocation (VERA) System has served as the basis for allocating the congressionally appropriated medical care budget of the Department of Veterans Affairs (DVA) to its regional networks. Concerned that the VERA system may not allocate resources in a manner consistent with its mission, Congress requested a study of the system and how allocations are affected by a number of factors, including infrastructure age, extreme weather conditions, and participation in medical education. This report describes the results of RAND's initial analysis. Because of the project's short time frame, only qualitative analysis was performed. Among the findings were that health care delivery costs may be affected by the age, physical condition, and historical significance of a VISN's capital infrastructure, factors for which VERA does not currently adjust. An additional finding was that VERA's current case-mix adjustment may not adequately account for differences in the average health status of veterans across networks. The influence on costs and access to care of factors such as weather extremes was less clear. In spite of its possible shortcomings, VERA appeared to be designed

to meet its objectives more closely than did previous VA budget allocation systems. A plan was presented for further quantitative analysis of a number of critical issues that emerged from the current study.

**MR-1491-SAMHSA** Evidence Based Care Models for Recognizing and Treating Alcohol Problems in Primary Care Settings. K. E. Watkins, H. A. Pincus, T. L. Tanielian. 2001.

Alcohol-related problems are a significant public health concern in the United States. Effective treatments exist for the entire spectrum of alcohol related problems; however, fewer than half of those who need treatment actually receive it. This report discusses how a chronic disease management model can be adapted to improve the detection, treatment, and management of patients with alcohol-related problems in primary care settings. The report highlights the relevant literature and discusses issues and strategies for consideration in building, implementing, and evaluating a chronic care model for alcohol problems in primary care settings. Within the context of the chronic care model, the authors also review the characteristics of the most widely used alcohol disorder screening instruments suitable for use in primary care settings. Further work is needed to develop and collect the necessary tools and resources to implement the model and to determine its feasibility and potential impact.

## RGS DISSERTATIONS

**RGSD-157** Assessing Patient Experiences with Healthcare in Multi-Cultural Settings. L. S. Morales. 2001.

## REPRINTS

**RP-889** Impact of Disseminating Quality Improvement Programs for Depression in Managed Primary Care: A Randomized Controlled Trial. K. B. Wells, C. D. Sherbourne, M. Schoenbaum, N. Duan, L. S. Meredith, J. Unutzer, J. Miranda, M. Carney, L. V. Rubenstein. 2001.

Context: Care of patients with depression in managed primary care settings often fails to meet guideline standards, but the long-term impact of quality improvement (QI) programs for depression care in such settings is unknown. Objective: To determine if QI programs in managed care practices for depressed primary care patients improve quality of care, health outcomes, and

employment. Design: Randomized controlled trial initiated from June 1996 to March 1997. Setting: Forty-six primary care clinics in 6 US managed care organizations. Participants: Of 27332 consecutively screened patients, 1356 with current depressive symptoms and either 12-month, lifetime, or no depressive disorder were enrolled. Interventions: Matched clinics were randomized to usual care (mailing of practice guidelines) or to 1 of 2 QI programs that involved institutional commitment to QI, training local experts and nurse specialists to provide clinician and patient education, identification of a pool of potentially depressed patients, and either nurses for medication follow-up or access to trained psychotherapists. Main Outcome Measures: Process of care (use of antidepressant medication, mental health specialty counseling visits, medical visits for mental health problems, any medical visits), health outcomes (probable depression and health-related quality of life *HRQOL*), and employment at baseline and at 6- and 12-month follow-up. Results: Patients in QI (n = 913) and control (n = 443) clinics did not differ significantly at baseline in service use, *HRQOL*, or employment after nonresponse weighting. At 6 months, 50.9% of QI patients and 39.7% of controls had counseling or used antidepressant medication at an appropriate dosage ( $P < .001$ ), with a similar pattern at 12 months (59.2% vs 50.1%;  $P = .006$ ). There were no differences in probability of having any medical visit at any point (each  $P > \text{or} = .21$ ). At 6 months, 47.5% of QI patients and 36.6% of controls had a medical visit for mental health problems ( $P = .001$ ), and QI patients were more likely to see a mental health specialist at 6 months (39.8% vs 27.2%;  $P < .001$ ) and at 12 months (29.1% vs 22.7%;  $P = .03$ ). At 6 months, 39.9% of QI patients and 49.9% of controls still met criteria for probable depressive disorder ( $P = .001$ ), with a similar pattern at 12 months (41.6% vs 51.2%;  $P = .005$ ). Initially employed QI patients were more likely to be working at 12 months relative to controls ( $P = .05$ ). Conclusions: When these managed primary care practices implemented QI programs that improve opportunities for depression treatment without mandating it, quality of care, mental health outcomes, and retention of employment of depressed patients improved over a year, while medical visits did not increase overall. Originally published in *Journal of the American Medical Association*, v. 283, no. 2, Jan. 12, 2000.

**RP-914** The Evolution of Drug Initiation: From Social Networks to Public Markets. J. P. Caulkins. 2001.

This paper seeks to integrate two competing notions of what drives initiation into illicit drug use, the so-called "snowball model" of sellers recruiting new customers and the "social contagion" model of current users recruiting friends into drug use. The model hypothesizes that both occur, but in distinct phases of the drug epidemic. The

data are insufficient to validate the model, but inasmuch as the model is valid the principal policy conclusion is that interventions that reduce the "snowball effect" in Phase I may substantially reduce consumption in Phase II and overall. Originally published in *Optimization, Dynamics, and Economic Analysis—Essays in Honor of Gustav Feichtinger*.

**RP-922** Structured Implicit Review: A New Method for Monitoring Nursing Care Quality. M. Pearson, J. L. Lee, B. L. Chang, M. N. Elliott, K. L. Kahn, L. V. Rubenstein. 2001.

**BACKGROUND:** Nurses' independent decisions about assessment, treatment, and nursing interventions for hospitalized patients are important determinants of quality of care. Physician peer implicit review of medical records has been central to Medicare quality management and is considered the gold standard for reviewing physician care, but peer implicit review of nursing processes of care has not received similar attention. **OBJECTIVE:** The objective of this study was to develop and evaluate nurse structured implicit review (SIR) methods. **RESEARCH DESIGN:** We developed SIR instruments for rating the quality of inpatient nursing care for congestive heart failure (CHF) and cerebrovascular accident (CVA). Nurse reviewers used the SIR form to rate a nationally representative sample of randomly selected medical records for each disease from 297 acute care hospitals in 5 states (collected by the RAND-HCFA Prospective Payment System study). **SUBJECTS:** The study subjects were elderly Medicare inpatients with CHF (n = 291) or CVA (n = 283). **MEASURES:** The authors developed and tested scales reflecting domains of nursing process, evaluated interrater and interitem reliability, and assessed the extent to which items and scales predicted overall ratings of the quality of nursing care. **RESULTS:** Interrater reliability for 14 of 16 scales (CHF) or 10 of 16 scales (CVA) was  $> \text{or} = 0.40$ . Interitem reliability was  $> 0.80$  for all but 1 scale (both diseases). Functional Assessment, Physical Assessment, and Medication Tracking ratings were the strongest predictors of overall nursing quality ratings ( $P < 0.001$  for each). **CONCLUSIONS:** Nurse peer review with SIR has adequate interrater and excellent scale reliabilities and can be a valuable tool for assessing nurse performance. Originally published in *Medical Care*, v. 38, no. 11, Nov. 2000.

**RP-928** Anticipatory Guidance: What Information Do Parents Receive? What Information Do They Want? M. A. Schuster, N. Duan, M. Regalado, D. J. Klein. 2001.

**OBJECTIVE:** To determine whether parents are receiving anticipatory guidance, whether they could use more information on anticipatory guidance topics, and how receipt of anticipatory guidance relates to satisfaction with care. **DESIGN AND SAMPLE:** Analysis of data from a

telephone interview of 2017 respondents between July 1995 and January 1996. A stratified random-digit dialing design was used to obtain a nationally representative sample of parents with children between 0 and 3 years old. **MAIN OUTCOME MEASURES:** Discussions with a physician or nurse about 6 anticipatory guidance topics and whether parents could use more information on these topics. Willingness of parents to pay extra to discuss these topics and receive additional care. Ratings of how well clinicians provide health care. **RESULTS:** The percentage of parents who had not discussed each subject with a clinician varied by topic: newborn care (< 3 months old), 38%; crying, 65%; sleep patterns, 59%; encouraging learning, 77%; discipline (ages 6–36 months), 75%; and toilet training (ages 18–36 months), 66%. Thirty-seven percent of parents had not discussed any of these topics. Among parents who had not discussed a particular issue, the percentage who reported that they could use more information ranged from 22% for both newborn care and crying to 55% for encouraging learning; similar percentages who had discussed the topics could also use more information. Parents who had discussed more of these topics with a clinician were more likely to report excellent care. Parents who could use more information on a larger number of topics were much more willing to pay for additional care. **CONCLUSIONS:** Although anticipatory guidance is considered an important component of well-child care, the majority of parents reported that they had not discussed most standard topics with a clinician. Many parents could use more information on these topics. Effort is required to provide parents with the information they need to take good care of their children. Originally published in *Archives of Pediatrics and Adolescent Medicine*, v. 154, no. 12, Dec. 2000

**RP-941** Healthcare Issues at the End of Life. J. Lynn, M. W. Schall, C. Milne, K. M. Nolan, A. Kabcenell. 2001.

Originally published in *Journal of the American Medical Association and the Joint Commission Journal on Quality Improvement*.

**RP-943** Promoting Adolescent Health: Worksite-Based Interventions with Parents of Adolescents. M. A. Schuster, K. L. Eastman, J. E. Fielding, M. J. Rotheram-Borus, L. L. Franzoi, D. E. Kanouse. 2001.

A promising public health approach for reducing adolescent risk behavior is to recognize and support the role of parents in promoting healthful behaviors. Although there are various settings where parents can be reached, this article focuses on one particular setting—the parent's place of employment. The article discusses the development and implementation of parenting programs for parents of adolescents. Such programs are new and should be evaluated to determine whether they are

effective. Originally published in *Journal Of Public Health Management and Practice*, v. 7, no. 2, Mar. 2001.

**RP-944-1** Measuring the Incremental Cost of Clinical Cancer Research. D. P. Goldman, M. Schoenbaum, A. L. Potosky, J. C. Weeks, S. H. Berry, J. J. Escarce, B. Weidmer, M. L. Kilgore, N. Waggle, J. L. Adams, R. A. Figlin, J. H. Lewis, J. Cohen, R. Kaplan, M. McCabe. 2001.

Evidence suggests that insurers limit access to clinical trials because of cost concerns. Denial of coverage for treatment in a clinical trial limits patient access to trials and could limit clinical research. Public and private efforts are underway to change these policies, but their status is unclear, although preliminary estimates suggest that such changes would not be expensive. Previous studies found that treatment costs in clinical trials are similar to costs of standard therapy; however, it is difficult to generalize from these studies. As part of the Cost of Cancer Treatment Study, an ongoing effort to produce generalizable estimates of the incremental costs of government-sponsored cancer trials, the authors are conducting a one-year retrospective study of costs for 1,500 cancer patients recruited from a randomly selected sample of institutions in the U.S. The results of the study should be of great interest to insurers and the research community as they consider permanent ways to finance cancer trials. Originally published in *Journal of Clinical Oncology*, v. 19, no. 1, Jan. 1, 2001.

**RP-946** Are Better Ratings of the Patient-Provider Relationship Associated with Higher Quality Care for Depression? L. S. Meredith, M. Orlando, N. Humphrey, P. Camp, C. D. Sherbourne. 2001.

**Background.** The interpersonal patient-provider relationship (PPR) is an essential part of health care quality, particularly for patients with depression, yet little is known neither about how to measure this relationship nor about its association with quality of care. **Objectives.** To evaluate properties of patient rating measures, understand the relation between 2 types of ratings, and determine the association of ratings with quality depression care. **Setting and Participants.** 1,104 patients with current depressive symptoms and life time or 12-month disorder identified through screening 27,332 consecutive primary care visitors in 6 managed care organizations participating in Partners in Care (PIC). **Design.** Cross-sectional analysis of 18-month data (collected in 1998) after the start of PIC depression quality improvement (QI) interventions (in which clinics were randomized to 1 of 2 QI interventions or usual care). **Measures.** Patient ratings of the interpersonal relationship with the primary care provider and satisfaction with health care, and quality of depression care indicators. **Analysis.** Factor analysis and multitrait scaling to evaluate the

psychometric properties of multiitem constructs and analysis of covariance to evaluate associations between patient ratings and quality. Results. Patient ratings had high internal consistency and met criteria for discriminant validity tapping unique aspects of care. Patients receiving quality care, especially for medication use, had significantly higher ratings of the interpersonal relationship (by 22% to 27% of a SD) and were more satisfied (by 26% to 34% of a SD) than patients who did not receive quality care. Conclusions. Ratings of the interpersonal relationship and satisfaction measure distinct aspects of care and are positively associated with quality care for depression. Originally published in *Medical Care*, v. 39, no. 4, 2001.

**RP-949** Correlates of HIV Risk Among Female Sex Partners of Injecting Drug Users in a High-Seroprevalence Area. M. Y. Iguchi, D. A. Bux, H. Kushner, V. M. Lidz. 2001

Risk factors for HIV infection were examined in 520 female sex partners (SPs) of injecting drug users (IDUs); 16% tested HIV positive (40% among former IDUs). In multivariate analyses, sex trade was associated with risk of HIV infection, whereas race, age, history of pneumonia or genital herpes, high self-rated AIDS risk, and IDU history were related to greater risk. Among women with no IDU history, cohabitation with a SP (not trading sex) predicted higher risk; having a female SP was also associated with higher risk. Secondary analyses suggest that total unprotected contacts with IDUs and both sex trade and cohabitation might account for these findings. The data suggest that, for female SPs of IDUs, reducing numbers of sex partners per se may not confer adequate protection from HIV. For women in committed relationships with IDUs, interventions should address contextual factors in relationships that elevate risk and complicate prevention. Originally published in *Evaluation and Program Planning*, v. 24, 2001.

**RP-950** Factors Associated with Readiness to Change Drug Use Among Needle-Exchange Users. R. N. Bluthenthal, A. Gogineni, D. Longshore, M. Stein. 2001.

To determine if frequent needle-exchange program (NEP) use is associated with lower readiness to change drug use, NEP clients in Providence, RI, were interviewed regarding their drug use, HIV risk, health, and past use of drug treatment services in 1997–1998. Readiness to change drug use was assessed using a nine-step decision ladder. Based on this assessment, 14.3% of the sample were classified as precontemplators (24/168), 29.2% were in the contemplation stage (49/168), and 56.5% were in the determined or ready to change stage (95/168). The authors found that mean number of NEP visits was 25.2 among precontemplators, 28.7 among contemplators, and 22.5 among those in the determination stage. In multivariate

analysis, an inverse relationship between having ever been in alcohol treatment and higher readiness to change drug use was the only significant association. In this exploratory study, the authors found that more-frequent NEP participation did not affect readiness to change drug use among intravenous drug users. Given the high proportion of NEP clients ready to change drug use, improved linkages between NEPs and substance abuse treatment appear warranted. Originally published in *Drug and Alcohol Dependence*, V. 62, 2001.

**RP-952** Does Obesity Contribute as Much to Morbidity as Poverty or Smoking? R. Sturm, K. B. Wells. 2001.

Objectives: The prevalence of obesity is increasing in America, but its impact on morbidity relative to other health risks is unclear. This paper compares the effects of overweight, poverty, smoking, and problem drinking on occurrence of chronic conditions and health-related quality-of-life. Methods: Nationally representative household telephone survey of 9585 adults fielded in 1998, using self-reported measures of height and weight (body mass index, BMI), poverty (below federal poverty level), smoking status, recent problem drinking, major chronic conditions, and health-related quality-of-life by SF-12 global scales. Regression analyses were used to estimate effects of health risk factors on morbidity. Results: 36% of adults are overweight but not obese ( $25 \leq \text{BMI} < 30$ ) and another 23% are obese ( $\text{BMI} \geq 30$ ). Controlling for demographics, obesity is associated with more chronic conditions and worse physical health-related quality of life ( $p$ 's  $< .01$ ). While lifetime smoking history and poverty also significantly predict having chronic conditions, their effect sizes are significantly smaller. Even after controlling for chronic conditions, obesity predicts physical health-related quality of life, in that case with an effect size similar to poverty for both men and women and similar to smoking for men and larger than smoking for women. The effect of problem drinking is always smaller. Conclusions: Obesity is highly prevalent and associated with at least as much morbidity in terms of chronic medical conditions and reduction in physical health-related quality-of-life as are poverty, smoking, and problem drinking. Nevertheless, the latter have achieved more consistent attention in recent decades in clinical practice and public health policy. Originally published in *Public Health*, v. 115, 2001.

**RP-961** Sex Differences in Predictors of Adolescent Smoking Cessation. P. L. Ellickson, J. S. Tucker, D. J. Klein. 2001.

Sex differences in predictors of smoking cessation were investigated among 337 male and 490 female participants in the RAND adolescent panel study. Participants reported smoking at least 11–20 times during the past year at Grade

10, with cessation defined as not smoking during the past year at Grade 12. Controlling for demographics, sex-specific analyses indicated that girls who quit smoking within 2 years had friends who smoked less frequently, perceived less parental approval of their smoking, had weaker intentions to continue smoking, used marijuana less frequently, attended fewer different schools, were more likely to have an intact nuclear family, experienced greater peer support, and rated themselves as healthier. Similar analyses for boys yielded results that were generally weaker and nonsignificant, with smoking quantity accounting for several associations in the sex-specific models. Despite these differences, interaction tests revealed significant sex differences for only three predictors. Implications of these results for understanding adolescent smoking cessation are discussed. Originally published in *Health Psychology*, v. 20, no. 3, 2001.

**RP-963** Fertility Desires and Intentions of HIV-Positive Men and Women. J. L. Chen, K. A. Phillips, D. E. Kanouse, R. L. Collins, A. Miu. 2001.

**CONTEXT:** HIV-positive men and women may have fertility desires and may intend to have children. The extent of these desires and intentions and how they may vary by individuals' social and demographic characteristics and health factors is not well understood. **METHODS:** Interviews were conducted from September through December 1998 with 1,421 HIV-infected adults who were part of the HIV Cost and Services Utilization Study, a nationally representative probability sample of 2,864 HIV-infected adults who were receiving medical care within the contiguous United States in early 1996. **RESULTS:** Overall, 28–29% of HIV-infected men and women receiving medical care in the United States desire children in the future. Among those desiring children, 69% of women and 59% of men actually expect to have one or more children in the future. The proportion of HIV-infected women desiring a child in the future is somewhat lower than the overall proportion of U.S. women who desire a child. The fertility desires of HIV-infected individuals do not always agree with those of their partners: As many as 20% of HIV-positive men who desire children have a partner who does not. Generally, HIV-positive individuals who desire children are younger, have fewer children and report higher ratings of their physical functioning or overall health than their counterparts who do not desire children, yet desire for future childbearing is not related to measures of HIV progression. HIV-positive individuals who expect children are generally younger and less likely to be married than those who do not. Multivariate analyses indicate that black HIV-positive individuals are more likely to expect children in the future than are others. While HIV-positive

women who already have children are significantly less likely than others both to desire and to expect more births, partner's HIV status has mixed effects: Women whose partner's HIV status is known are significantly less likely to desire children but are significantly more likely to expect children in the future than are women whose partner's HIV status is unknown. Moreover, personal health status significantly affects women's desire for children in the future but not men's, while health status more strongly influences men's expectations to have children. **CONCLUSIONS:** The fact that many HIV-infected adults desire and expect to have children has important implications for the prevention of vertical and heterosexual transmission of HIV, the need for counseling to facilitate informed decision-making about childbearing and childrearing, and the future demand for social services for children born to infected parents. Originally published in *Family Planning Perspectives*, v. 33, no. 4, 2001.

**RP-971** The RAND-36 Measure of Health-Related Quality of Life. R. D. Hays, L. S. Morales. 2001.

The RAND-36 is perhaps the most widely used health-related quality of life (HRQoL) survey instrument in the world today. It is comprised of 36 items that assess eight health concepts: physical functioning, role limitations caused by physical health problems, role limitations caused by emotional problems, social functioning, emotional well-being, energy/fatigue, pain, and general health perceptions. Physical and mental health summary scores are also derived from the eight RAND-36 scales. This paper provides example applications of the RAND-36 cross-sectionally and longitudinally, provides information on what a clinically important difference is for the RAND-36 scales, and provides guidance for summarizing the RAND-36 in a single number. The paper also discusses the availability of the RAND-36 in multiple languages and summarizes changes that are incorporated in the latest version of the survey. Originally published in *Annals of Medicine*, v. 33, 2001.

## CORPORATE PUBLICATIONS

**CP-22-0108** RAND Review. Vol. 25, No. 2, Summer 2001. E. A. McGlynn, R. H. Brook, M. Bernstein, P. Dreyer, M. Hanson, J. Kulick, J. Godges. 2001.

A feature article proposes a national tracking system to measure the quality of health care in America and then proposes a strategy to keep public pressure on health care providers to improve their services.

## DRAFTS

**DRU-2642-NICHD/USAID** Pregnancy Care in Rural Guatemala: Results from the Encuesta Guatemalteca De Salud Familiar. N. Goldman, D. A. Gleib, A. R. Pebley, H. Delgado. 2001.

## JOURNAL ARTICLES AND BOOK CHAPTERS (Not Available from RAND)

**LRP-200100-01** A Review of Health-Related Quality-of-Life Measures in Stroke. B. A. Golomb, B. G. Vickrey, R. D. Hays.

The objective of this review was to evaluate health-related quality of life (HR-QOL) measures for use with patients with stroke. HR-QOL measures are increasingly used for assessment in many health conditions; these measures may serve an important role in evaluating the impact of stroke and of stroke interventions. HR-QOL measures used in patients with stroke should: (i) cover the domains of HR-QOL that may be affected by stroke; (ii) have administration characteristics suitable for use in patients with stroke; and (iii) have undergone reliability and validity assessment in patients with stroke. The present study evaluates HR-QOL measures with reference to these requirements. A systematic literature review was conducted to identify and evaluate HR-QOL measures of potential use in studies of patients with stroke. Identified measures were assessed with regard to stroke-relevant domains covered, measure characteristics (e.g., self-administration versus administration by an interviewer, interviewer time to complete) and psychometric properties of reliability and validity. The measures evaluated vary widely on domains covered, and limited assessment of the performance of HR-QOL measures has been conducted in patients with stroke. No existing measure comprehensively covers all relevant domains or addresses fully the issues of obtaining and combining HR-QOL assessments in patients and proxies in many stroke populations. Additional psychometric testing in stroke populations is needed for existing HR-QOL measures. In addition, stroke-targeted HR-QOL measures need to be developed and evaluated with patients with stroke. Published in *Pharmacoeconomics*, v. 19, no. 2, 2001, p. 155–185.

**LRP-200100-02** Diffusion of Ideas About Personal Hygiene and Contamination in Poor Countries: Evidence from Guatemala. N. Goldman, A. R. Pebley, M. Beckett.

In this paper, The authors explore the diffusion of beliefs pertaining to the causes of childhood diarrhea in rural Guatemala. The analysis focuses on the importance of

interpersonal and impersonal contacts as conduits for information and norms related to hygiene and contamination. Estimates from multivariate models reveal that there is evidence of a diffusion process through social contacts, primarily through interpersonal ones. The analysis also identifies striking differences between (1) the diffusion process related to hygiene (e.g. dirtiness) and that related to contamination (e.g. pathogens); and (2) beliefs about the causes of diarrheal illness among children in general and those among respondents' own children. Published in *Social Science and Medicine*, v. 52, 2001, p. 53–69.

**LRP-200100-04** Are Better Ratings of the Patient-Provider Relationship Associated with Higher Quality Care for Depression? L. S. Meredith, M. Orlando, N. Humphrey, P. Camp, C. D. Sherbourne.

**Background.** The interpersonal patient-provider relationship (PPR) is an essential part of health care quality, particularly for patients with depression, yet little is known neither about how to measure this relationship nor about its association with quality of care. **Objectives.** To evaluate properties of patient rating measures, understand the relation between 2 types of ratings, and determine the association of ratings with quality depression care. **Setting and Participants.** 1,104 patients with current depressive symptoms and life time or 12-month disorder identified through screening 27,332 consecutive primary care visitors in 6 managed care organizations participating in Partners in Care (PIC). **Design.** Cross-sectional analysis of 18-month data (collected in 1998) after the start of PIC depression quality improvement (QI) interventions (in which clinics were randomized to 1 of 2 QI interventions or usual care). **Measures.** Patient ratings of the interpersonal relationship with the primary care provider and satisfaction with health care, and quality of depression care indicators. **Analysis.** Factor analysis and multitrait scaling to evaluate the psychometric properties of multiitem constructs and analysis of covariance to evaluate associations between patient ratings and quality. **Results.** Patient ratings had high internal consistency and met criteria for discriminant validity tapping unique aspects of care. Patients receiving quality care, especially for medication use, had significantly higher ratings of the interpersonal relationship (by 22% to 27% of a SD) and were more satisfied (by 26% to 34% of a SD) than patients who did not receive quality care. **Conclusions.** Ratings of the interpersonal relationship and satisfaction measure distinct aspects of care and are positively associated with quality care for depression. Published in *Medical Care*, v. 39, no. 4, 2001, p. 349–360.

**LRP-200100-05** Lower Urinary Tract Symptoms Suggestive of Benign Prostatic Obstruction: How Can

Clinical Expertise Contribute to Rational Management? H. J. Stoevelaar, J. McDonnell, J. L. H. R. Bosch, J. P. Kahan.

**Objective:** To perform a systematic analysis of clinical expertise on treatment for benign prostatic hyperplasia (lower urinary tract symptoms (LUTS) suggestive of benign prostatic obstruction (BPO)) and to investigate the usefulness of these data in further guideline development. **Methods:** A modified Delphi method was used to analyze the opinions of a panel of 15 European urologists on the appropriateness of 4 common treatments for 1,152 "indications" (hypothetical cases) for LUTS suggestive of BPO. Each indication consisted of a unique combination of 9 diagnostic variables, found to be relevant in treatment choice in previous research. The study population was restricted to patients for whom current guidelines do not provide clear indications on the most appropriate treatment. The panelists individually rated the appropriateness of three active treatments (surgery,  $\alpha$ -adrenoceptor antagonists, finasteride) using a 9-point scale, all in comparison with "watchful waiting." Aggregate panel judgments were calculated from individual ratings for each indication (appropriate, inappropriate, and uncertain). The relationship between diagnostic characteristics and panel opinions was analyzed using logistic regression methods. The results were compared to those of an identical panel study including 12 Dutch urologists. **Results:** Strong agreement existed for 42.5% of the indications, while strong disagreement was found in only 0.1%. For patients who had not previously been treated for LUTS, surgery was considered appropriate in 44% of the indications. For  $\alpha$ -adrenoceptor antagonists and finasteride these percentages were 56 and 6 respectively. Strong contra-indications were found only for finasteride (34%). Logistic regression analysis demonstrated consistent panel opinions, indicating a strong cumulative impact of almost all diagnostic variables on the panel judgment "appropriate". The figures on appropriateness were highly comparable to the results of the Dutch study (overall agreement 84%, kappa 0,76). A computer program was constructed to facilitate the implementation and evaluation of the panel recommendations in daily clinical practice. **Conclusions:** Given the consistency of the panel opinions, the results may be useful in complementing evidence-based guidelines for LUTS suggestive of BPO in the gray area of treatment choice. Published in *European Urology*, v. 39, suppl. 3, 2001, p. 13-19.

**LRP-200100-06** Depression in Youth: Psychosocial Interventions. J. R. Asarnow, L. Jaycox, M. C. Tompson.

Witnessed over the past 20 years are major advances in knowledge regarding depression in children and adolescents. Although additional research is needed, clinicians can now turn to treatment strategies with

demonstrated efficacy. In this article the authors review the literature on psychosocial interventions for depression in youth and offer a working model to guide the treatment of depressed youth. They begin with a brief overview of the model, followed by a review of the treatment efficacy and prevention literatures. They offer some caveats that impact the ability to move from this treatment literature to the real world of clinical practice. The authors conclude by considering how extant research can inform treatment decisions and highlight critical questions that need to be addressed through future research. Published in *Journal of Clinical Child Psychology*, v. 30, no. 1, 2001, p. 33-47.

**LRP-200100-08** The Appropriateness of Treatment of Benign Prostatic Hyperplasia : A Comparison of Dutch and Multinational Criteria. J. McDonnell, H. J. Stoevelaar, J.L.H. R. Bosch, J. P. Kahan.

Over the last decade, a number of organisations have developed clinical guidelines, typically at a national level, in order to increase appropriate health care. This raises the question as to whether it is possible to develop guidelines, applicable on the national level, at an international level. In order to examine this, we compared the appropriateness criteria for the treatment of benign prostatic hyperplasia ratings developed by two panels, one a single-nationality (Dutch) panel, the other a multinational (European) panel. The panels, both consisting of experienced urologists, used a modified Delphi process to rate 1152 indications for the most common treatments (surgery,  $\alpha$ -blocker, finasteride and watchful waiting) on a nine-point scale. This article describes the similarities and differences between the ratings produced by the panels. The appropriateness ratings were identical for 84% of the indications ( $K = 0.76$ ). The difference in the scores for individual indications was zero in 41% of indications and less than or equal to two in 99% of indications. This study provides strong evidence that a multinational panel can deliver essentially the same appropriateness ratings for BPH as a national panel. Developing appropriateness criteria on an international level may result in significant savings and may help contribute to the reduction of undesirable practice variation. Published in *Health Policy*, v. 57, 2001, p. 45-56.

**LRP-200100-09** Changes in Alcohol-Related Inpatient Care: An International Trend Comparison. Y. Bao, D. Sauerland, R. Sturm, RAND Health Program.

This paper studies two utilization measures of alcoholism treatment, discharge rate and average length of stay, in the United States, Australia, Sweden and Canada. The results suggest that the decline in length of stay and discharges in the past 15 years was an international phenomenon and not unique to the U.S. However, data for length of stay also suggests that the biggest decline in the United States coincided with the fastest growth of managed behavioral

health care. Published in *Journal of Addictive Diseases*, v. 20, no. 2, 2001, p. 97–104.

**LRP-200100-10** Evaluating the Quality of Care. E. A. McGlynn, R. H. Brook.

The main purpose of this chapter is to review various methods for assessing quality of care and to summarize some of what is known about the current level of quality in the United States. The authors begin by considering criteria for selecting topics for quality assessment. Then they present a conceptual framework useful for organizing evaluation of quality. The definitions, methods, and state of the art in assessing the structure, process, and outcomes of care are subsequently discussed. The bottom line to this chapter is that scientifically sound methods exist for assessing quality and that they must be employed systematically in the future to guard against deterioration in quality that might otherwise occur as an unintended result of organizational and financial changes in the health services system. Published in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, second edition / edited by R. M. Andersen, T. H. Rice, G. R. Kominski (San Francisco, CA: Jossey-Bass Inc., 2001), Chapter 7, p. 150–182.

**LRP-200100-12** The RAND-36 Measure of Health-Related Quality of Life. R. D. Hays, L. S. Morales.

The RAND-36 is perhaps the most widely used health-related quality of life (HRQoL) survey instrument in the world today. It is comprised of 36 items that assess eight health concepts: physical functioning, role limitations caused by physical health problems, role limitations caused by emotional problems, social functioning, emotional well-being, energy/fatigue, pain, and general health perceptions. Physical and mental health summary scores are also derived from the eight RAND-36 scales. This paper provides example applications of the RAND-36 cross-sectionally and longitudinally, provides information on what a clinically important difference is for the RAND-36 scales, and provides guidance for summarizing the RAND-36 in a single number. The paper also discusses the availability of the RAND-36 in multiple languages and summarizes changes that are incorporated in the latest version of the survey. Published in *Annals of Medicine*, v. 33, 2001, p. 350–357.

**LRP-200100-13** Homeless Women's Gynecological Symptoms and Use of Medical Care. S. L. Wenzel, R. Andersen, D. S. Gifford, L. Gelberg, RAND Health Program.

Information is lacking on homeless women's gynecological symptoms and use of medical care for symptoms. This paper documents and explains gynecological symptoms and conditions and use of

medical care in a probability sample of 974 reproductive-age (15–44) homeless women. Two-thirds of women reported symptoms during the previous year; 71 percent of those received medical care for their gynecological symptoms. Pregnancy, drug dependence, more episodes of homelessness, and general physical health symptoms were positively associated with a number of gynecological symptoms. Gynecological symptoms, younger age, better perceived health, and insurance coverage were positively associated with medical care. Those findings support the importance of medical care and other treatment and support services for homeless women, including expanded care during pregnancy and substance abuse treatment. Health insurance coverage and an interruption in the cycle of homelessness also appear vital to women's health. Published in *Journal of Health Care for the Poor and Underserved*, v. 12, no. 3, 2001, p. 323–341.

**LRP-200100-14** Measuring Outcomes and Health-Related Quality of Life. P. A. Ganz, M. S. Litwin.

Until recently, and with the exception of a few studies already cited, health related quality of life has been included infrequently in traditional health services research. The expansion and development of HRQL measurement has emerged primarily from clinical research. What is needed urgently is careful and appropriate inclusion of HRQL outcomes in traditional health services research. Similarly, researchers in clinical settings who are measuring HRQL should account for the structure and process of care in designing their research and data collection. As indicated throughout this chapter, the potential for accomplishing this goal is on the horizon. Published in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, second edition second edition / edited by R.M. Andersen, T.H. Rice, G.R. Kominski (San Francisco, CA: Jossey-Bass Inc., 2001), Chapter 6, p. 127–149.

**LRP-200100-15** Public Release of Information on Quality. E. A. McGlynn, J. L. Adams.

Routine reports to the public on the quality of health care are one response to concerns about accountability. Public release of information on quality is intended to have two main effects: to facilitate informed choice and to stimulate quality improvement. The purpose of this chapter is to (1) describe the type of information that is currently being publicly released, (2) discuss some of the methodological issues that arise in producing information for public release, and (3) summarize what is known about the use of information on quality for consumer choice and quality improvement. Published in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, 2nd ed. / edited by R.M. Andersen, T.H. Rice, G.R. Kominski (San Francisco, CA: Jossey-Bass Inc., 2001), Chapter 8, p. 183–202.

**LRP-200100-16** Using Data to Enhance the Expert Panel Process. S. M. Oishi, S. C. Morton, J. C. Beck, R. D. Hays, K. L. Spritzer, J. M. Partridge, A. Fink.

**OBJECTIVE:** To enhance the validity of a well-known expert panel process, the authors used data from patient surveys to identify and correct rating errors. **METHODS:** They used the two-round RAND/UCLA panel method to rate indications of harmful (presence of problems), hazardous (at risk for problems), and nonhazardous (no known risks) drinking in older adults. Results from the panel provided guidelines for classifying older individuals as harmful, hazardous, or nonhazardous drinkers, using a survey. The classifications yielded unexpectedly high numbers of harmful and hazardous drinkers. The authors hypothesized possible misclassifications of drinking risks and used the survey data to identify indications that may have led to invalid ratings. They modified problematic indications and asked three clinician panelists to evaluate the clinical usefulness of the modifications in a third panel round. They revised the indications based on panelist response and reexamined drinking classifications. **RESULTS:** Using the original indications, 48% of drinkers in the sample were classified as harmful, 31% as hazardous, and 21% as nonhazardous. A review of the indications revealed framing bias in the original rating task and vague definitions of certain symptoms and conditions. The modified indications resulted in classifications of 22% harmful, 47% hazardous, and 31% nonhazardous drinkers. **CONCLUSIONS:** Analysis of survey data led to identification and correction of specific errors occurring during the panel-rating process. The validity of the RAND/UCLA method can be enhanced using data-driven modifications. Published in *International Journal of Technology Assessment in Health Care*, v.17 no. 1, 2001, p. 125–136.

**LRP-200100-17** Health Reform for Children and Families. N. Halfon, M. Inkelas, D. Wood, M. A. Schuster.

Despite great technical advances and the development of important programs that have improved the health and changed the lives of many children, the system of care for children in the United States has yet to embody the principles of Bright Futures and other expert panels. Published in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, 2nd ed. / edited by R.M. Andersen, T.H. Rice, G.R. Kominski (San Francisco, CA: Jossey-Bass Inc., 2001), Chapter 11, p. 261–290.

**LRP-200100-18** Aids in the Twenty-First Century: Challenges for Health Services and Public Health. D. M. Mosen, D. R. Globe, W. E. Cunningham.

The epidemic of acquired immune deficiency syndrome (AIDS) presents to the health care system myriad challenge, which have changed over time. Health services providers and researchers must understand the needs of people infected with HIV, as well as accessibility to care, cost of care, and quality of services. In this chapter, we cover these issues in health services. Published in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, second edition / edited by R. M. Andersen, T. H. Rice, G. R. Kominski (San Francisco, CA: Jossey-Bass Inc., 2001), Chapter 10, p. 224–260.

**LRP-200100-19** Managed Care and the Growth of Competition. G. F. Kominski, G. Melnick.

Several significant incremental health care reforms were enacted by Congress during the 1990s. However, the failure to pass comprehensive national health care reform legislation meant that responsibility for restructuring the health care system fell primarily on the private sector and individual states. This chapter offers a review and synthesis of the empirical literature on the effects of managed care and competition and discusses the implications of current trends, what we have learned to date, and some directions for future research. Published in *Changing the U.S. Health Care System: Key Issues in Health Services Policy and Management*, second edition / edited by R. M. Andersen, T. H. Rice, G. R. Kominski (San Francisco, CA: Jossey-Bass Inc., 2001), Chapter 15, p. 389–405.

**LRP-200100-20** What Are Dynamic Models and How Can They Be Used? C. Godfrey, S. Parrott, M. Sutton, V. Waby, P. Young, C. Comiskey, M. Frisher, G. Hay, M. Hickman, J. Jager, J. Kahan, L. Kraus, R. Mollica, M. Postma, G. S. Tomba, R. Simon, C. Taylor, L. Wiessing.

This chapter synthesizes discussions and conclusions from three meetings of a group of experts from across Europe to consider the feasibility of developing dynamic models of drug use and related problems. The authors consider (1) potential policy questions, (2) types of models and their advantages and disadvantages, and (3) the potential for further research. Published in *Modelling Drug Use: Methods to Quantify and Understand Hidden Processes* / Godfrey, Wiessing, Hartnoll, (eds), 2001, Chapter 2, p. 33–50.

**LRP-200100-23** The Societal Costs of Chronic Major Depression. H. A. Pincus, A. R. Pettit.

Major depression is a widespread, often chronic disorder affecting the individual, his or her family, and society as a whole. It incurs tremendous social and financial costs in the form of impaired relationships, lost productivity, and

lost wages. Although chronic major depression is eminently treatable, it continues to be undertreated and underrecognized. This is particularly true in primary care settings, where physicians are usually the first to encounter chronic depression but are seldom trained to distinguish depression from other medical illnesses with similar symptoms. In addition, because of the stigma attached to depression, patients often characterize their symptoms as part of a physical illness or fail to report them to a clinician at all. This article discusses the epidemiology of depression, its impact and burden on society, and its special character (including diagnosis and treatment) as a chronic illness. Published in *Journal of Clinical Psychiatry*, v. 62, suppl., 6, 2001, p. 5–9.

**LRP-200100-24** Effects of Cost-Containment Strategies Within Managed Care on Continuity of the Relationship Between Patients with Depression and Their Primary Care Providers. L. S. Meredith, R. Sturm, P. Camp, K. B. Wells.

**Background.** Continuity of the relationship between patients and primary care providers (PCPs) is an important component of care from the consumer perspective that may be affected by variation in cost containment strategies within managed care. **Objective.** To evaluate the effects of cost containment strategies on the continuity of the relationship between their patients with depression and their PCPs. **Design.** Observational analysis of a 2-year panel of depressed patients who participated in a quality improvement intervention trial in 46 managed care practices. **Participants.** One thousand two hundred four patients with current depression who enrolled in a longitudinal study, completed the baseline survey, and were followed for 2 years. **Main Measures.** The dependent variable is probability of continuing the relationship between patients and their PCPs; explanatory variables include individual patient mental health benefits and cost-sharing, individual provider financial incentives, supply-side managed care policies, and patient ratings of the care received. **Results.** The average duration of the patient-PCP relationship was significantly longer among depressed patients who initially had less generous benefits for specialty care (higher copays,  $P = 0.02$  and fewer visits covered,  $P = 0.002$ ) and for patients whose PCPs received a performance-based salary bonus from a risk pool ( $P = 0.07$ ). **Conclusions.** For depressed patients, cost containment strategies, such as limits on specialty benefits and presence of clinician bonus payments typically used within managed care may increase, rather than decrease, PCP continuity. Whether increased PCP continuity is a desirable outcome depends on whether health care systems can provide high quality primary care and this merits further study. Published in *Medical Care*, v. 39, n. 10, 2001, p. 1075–1085.

**LRP-200100-25** Can Utility-Weighted Health-Related Quality-of-Life Estimates Capture Health Effects of Quality Improvement for Depression? C. D. Sherbourne, J. Unutzer, M. Schoenbaum, N. Duan, L. A. Lenert, R. Sturm, K. B. Wells.

Published in *Medical Care*, v. 39, no. 11, 2001, p. 1246–1259.

**LRP-200100-30** Alternative Treatments for Weight-Loss: Caveat Emptor. D. M. Studdert.

"Nontraditional" or "alternative" treatments are extremely popular, especially with respect to obesity and body composition. Although such treatments are widely used, it is not clear that these are supported by the existing data in the peer-reviewed literature. Herein, the author review the data on 18 methods/products advocated as potential anti-obesity/fat-reducing agents. The author found that none have been convincingly demonstrated to be safe and effective in two or more peer-reviewed publications of randomized double-blind placebo-controlled trials conducted by at least two independent laboratories. Nevertheless, some have plausible mechanisms of action and encouraging preliminary data that are sufficiently provocative to merit further research. Published in *Critical Reviews in Food Science and Nutrition*, v. 41, no. 1, 2001, p. 29–31.

**LRP-200100-31** A Randomized Comparative Trial of Testosterone and Protein Supplements for Weight Loss in HIV + Men. G. J. Wagner, J. G. Rabkin, R. Rabkin.

This report presents findings from a randomized trial that compared the efficacy of 1) 400 mg biweekly IM injections of testosterone plus daily "placebo" standard nutritional supplements (containing 8 g of protein per serving), 2) high protein (37 g per serving) supplements and placebo IM injections, and 3) both testosterone and high protein supplements, in the treatment of HIV-related weight loss. Sixty-five HIV+ men with <90% of normative body weight or body cell mass entered the study, of whom 54 (83%) completed the 12-week trial. In an intention to treat analysis, the response rates (defined as an increase of at least 5% in the ratio of body cell mass to height) for testosterone (55/o), high protein supplements (62%), and both testosterone and protein supplements (73%) were statistically similar ( $p = NS$ ). Amount of change in body weight, body cell mass, fat free mass and body fat from baseline to Week 12 (as measured by bioelectric impedance analysis), all of which were statistically significant within each group, did not differ across the three groups. Among all completed, the average gain in body weight and body cell mass after 12 weeks was 3.5 kgs and 2.0 kgs, respectively; 77% of the increase in body weight was fat free body mass, compared to 23% fat. These data support the efficacy of both testosterone

and high protein supplements as independent treatments for HIV-related weight loss, but do not demonstrate a further advantage of combining the treatments. Published in *Nutrition Research*, v. 21, 2001, p. 159-169.

**LRP-200100-32** Cross-Cultural Adaptation of Survey Instruments: The CAHPSa Experience. R. Weech-Maldonado, B. Weidmer, L. S. Morales, R. D. Hays.

This paper provides recommendations for the cross-cultural adaptation of survey instruments and illustrates with examples of what is being done in the Consumer Assessment of Health Plans Study (CAHPSa). Published in *Seventh Conference on Health Survey Research Methods* / edited by Marcie L. Lynamon and Richard A. Kulka (Hyattsville, Maryland: DHHS Publication, 2001), no. (PHS) 01-1013, p. 75-81.

**LRP-200101-02** Measuring the Incremental Cost of Clinical Cancer Research. D. P. Goldman, M. Schoenbaum, A. L. Potosky, J. C. Weeks, S. H. Berry, J. J. Escarce, B. Weidmer, M. L. Kilgore, N. Wagle, J. L. Adams, R. A. Figlin, J. H. Lewis, J. Cohen, R. Kaplan, M. McCabe.

**Purpose:** To summarize evidence on the costs of treating patients in clinical trials and to describe the Cost of Cancer Treatment Study, an ongoing effort to produce generalizable estimates of the incremental costs of government-sponsored cancer trials. **Methods:** A retrospective study of costs will be conducted with 1,500 cancer patients recruited from a randomly selected sample of institutions in the United States. Patients accrued to either phase II or phase III National Cancer Institute-sponsored clinical trials during a 15-month period will be asked to participate in a study of their health care utilization (n = 750). Costs will be measured approximately 1 year after their trial enrollment from a combination of billing records, medical records, and an in-person survey questionnaire. Similar data will be collected for a comparable group of cancer patients not in trials (n = 750) to provide an estimate of the incremental cost. **Results:** Evidence suggests insurers limit access to trials because of cost concerns. Public and private efforts are underway to change these policies, but their permanent status is unclear. Previous studies found that treatment costs in clinical trials are similar to costs of standard therapy. However, it is difficult to generalize from these studies because of the unique practice settings, insufficient sample sizes, and the exclusion of potentially important costs. **Conclusion:** Denials of coverage for treatment in a clinical trial limit patient access to trials and could impede clinical research. Preliminary estimates suggest changes to these policies would not be expensive, but these results are not generalizable. The Cost of Cancer Treatment Study is an ongoing effort to provide generalizable estimates of the incremental treatment cost of phase II and phase III cancer

trials. The results should be of great interest to insurers and the research community as they consider permanent ways to finance cancer trials. Published in *Journal of Clinical Oncology*, v. 19, no. 1, p. 105-110, Jan. 2001.

**LRP-200101-04** Economic Implications of Neonatal Intensive Care Unit Collaborative Quality Improvement. J. A. Rogowski, J. D. Horbar, P. E. Plsek, L. S. Baker, J. Deterding, W. H. Edwards, J. Hocker, A. D. Kantak, P. Lewallen, W. Lewis, E. Lewit, C. J. McCarroll, D. Mjuscse, N. R. Payne, P. Shiono, R. F. Soll, K. Leahy.

**Objective:** To make measurable improvements in the quality and cost of neonatal intensive care using a multidisciplinary collaborative quality improvement model. **Design:** Interventional study. Data on treatment costs were collected for infants with birth weight 501 to 1500 g for the period of January 1, 1994 to December 31, 1997. Data on resources expended by hospitals to conduct this project were collected in a survey for the period January 1, 1995 to December 31, 1996. **Setting:** Ten self-selected neonatal intensive care units (NICUs) received the intervention. They formed 2 subgroups (6 NICUs working on infection, 4 NICUs working on chronic lung disease). Nine other NICUs served as a contemporaneous comparison group. **Patients:** Infants with birth weight 501 to 1500 g born at or admitted within 28 days of birth between 1994 and 1997 to the 6 study NICUs in the infection group (N = 2993) and the 9 comparison NICUs (N = 2203); infants with birth weight 501 to 1000 g at the 4 study NICUs in the chronic lung disease group (N = 663) and the 9 comparison NICUs (N = 1007). **Interventions:** NICUs formed multidisciplinary teams which worked together to undertake a collaborative quality improvement effort between January 1995 and December 1996. They received instruction in quality improvement, reviewed performance data, identified common improvement goals, and implemented "potentially better practices" developed through analysis of the processes of care, literature review, and site visits. **Main Outcome Measures:** Treatment cost per infant is the primary economic outcome measure. In addition, the resources spent by hospitals in undertaking the collaborative quality improvement effort were determined. **Results:** Between 1994 and 1996, the median treatment cost per infant with birth weight 501 to 1500 g at the 6 project NICUs in the infection group decreased from \$57 606 to \$46 674 (a statistical decline); at the 4 chronic lung disease hospitals, for infants with birth weights 501 to 1000 g, it decreased from \$85 959 to \$77 250. Treatment costs at hospitals in the control group rose over the same period. There was heterogeneity in the effects among the NICUs in both project groups. Cost savings were maintained in the year following the intervention. On average, hospitals spent \$68 206 in resources to undertake the collaborative quality improvement effort between 1995 and 1996. Two thirds of

these costs were incurred in the first year, with the remaining third in the second year. The average savings per hospital in patient care costs for very low birth weight infants in the infection group was \$2.3 million in the post-intervention year (1996). There was considerable heterogeneity in the cost savings across hospitals associated with participation in the collaborative quality improvement project. Conclusion: Cost savings may be achieved as a result of collaborative quality improvement efforts and when they occur, they appear to be sustainable, at least in the short run. In high-cost patient populations, such as infants with very low birth weights, cost savings can quickly offset institutional expenditures for quality improvement efforts. Published in *Pediatrics*, v. 107, no. 1, Jan. 2001, p. 23–29 (Evanston, Ill.: American Academy of Pediatrics).

**LRP-200101-05** Arm Edema in Breast Cancer Patients. V. S. Erickson, M. Pearson, P. A. Ganz, J. Adams, K. L. Kahn.

The improvement in the life expectancy of women with breast cancer raises important questions about how to improve the quality of life for women sustaining complications of breast cancer treatment. In particular, attention to common problems, such as arm edema, is of critical importance. The authors reviewed published breast cancer guidelines and literature identified via MEDLINE(R) searches in an effort to summarize the research literature pertinent to management of breast cancer-related arm edema, including incidence, prevalence, and timing; risk factors; morbidity; prevention; diagnosis; and efficacy of nonpharmacologic and pharmacologic interventions. We found that arm edema is a common complication of breast cancer therapy that can result in substantial functional impairment and psychological morbidity. The risk of arm edema increases when axillary dissection and axillary radiation therapy are used. Recommendations for preventive measures, such as avoidance of trauma, are available, but these measures have not been well studied. Nonpharmacologic treatments, such as massage and exercise, have been shown to be effective therapies for lymphedema, but the effect of pharmacologic interventions remains uncertain. Comparing results across studies is complicated by the fact that the definitions of interventions and measures of outcomes and risk stratification vary substantially among studies. As arm edema becomes more prevalent with the increasing survival of breast cancer patients, further research is needed to evaluate the efficacy of preventive strategies and therapeutic interventions. Published in *Journal of the National Cancer Institute*, v. 93, no. 2, Jan. 17, 2001, p. 96–111 (Bethesda, Md.: U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Institutes of Health).

**LRP-200101-06** Quality of Life of Chronic Stable Angina Patients 4 Years After Coronary Angioplasty or Coronary Artery Bypass Surgery. B. Brorsson, S. Bernstein, R. H. Brook, L. Werko.

Objective: To evaluate the quality of life experienced by chronic stable angina patients with one- or two-vessel coronary artery disease treated with percutaneous transluminal coronary angioplasty (PTCA) or coronary artery bypass graft (CABG). Design: Prospective survey and review of medical records. Patients: Consecutive series of 601 Swedish chronic stable angina patients with one- or two-vessel disease who underwent CABG (n = 252) or PTCA (n = 349) between May 1994 and January 1995. Main Outcome Measures: The authors assessed five components of the Swedish Quality of Life Survey, anginal frequency, sublingual nitroglycerin use, and survival at 6, 21 and 48 months following coronary revascularization. Results: Anginal frequency and sublingual nitroglycerin use decreased for all patients by 6 months, but more amongst surgery patients than amongst angioplasty patients (P < 0.05). At 48 months, more bypass patients reported that they had not used sublingual nitroglycerin during the preceding 4 weeks (73.1 vs. 63.4%, P < 0.05). At 6 months, bypass patients had greater levels of improvement in physical functioning (15.3 vs. 10.5, P < 0.05) and general health perception (16.5 vs. 10.2, P < 0.05), than angioplasty patients. Bypass patients also had better relief from pain (19.4 vs. 14.6, P < 0.05), quality of sleep (17.6 vs. 4.6, P < 0.05) and general health perception (17.3 vs 12.1, P < 0.05) at 21 months. By 48 months follow-up, there was no longer any difference in these measures between groups. Conclusions: Both bypass surgery and angioplasty lead to improved quality of life for patients with chronic stable angina and one- or two-vessel coronary artery disease. Bypass surgery is associated with better quality of life at 6 months, but by 48 months quality of life is similar for patients initially treated by either procedure. Published in *Journal of Internal Medicine*, v. 249, no. 1, 2001, p.47–57.

**LRP-200101-09** The Quality of Care for Depressive and Anxiety Disorders in the United States. A. S. Young, R. Klap, C. D. Sherbourne, K. B. Wells.

Background: Depressive and anxiety disorders are prevalent and cause substantial morbidity. While effective treatments exist, little is known about the quality of care for these disorders nationally. The authors estimated the rate of appropriate treatment among the US population with these disorders, and the effect of insurance, provider type, and individual characteristics on receipt of appropriate care. Methods: Data are from a cross-sectional telephone survey conducted during 1997 and 1998 with a national sample. Respondents consisted of 1636 adults with a probable 12-month depressive or anxiety disorder as determined by brief diagnostic interview. Appropriate

treatment was defined as present if the respondent had used medication or counseling that was consistent with treatment guidelines. Results: During a 1-year period, 83% of adults with a probable depressive or anxiety disorder saw a health care provider (95% confidence interval *CI* 81%-85%) and 30% received some appropriate treatment (95% *CI*, 28%-33%). Most visited primary care providers only. Appropriate care was received by 19% in this group (95% *CI*, 16%-23%) and by 90% of individuals visiting mental health specialists (95% *CI*, 85%-94%). Appropriate treatment was less likely for men and those who were black, less educated, or younger than 30 or older than 59 years (range, 19–97 years). Insurance and income had no effect on receipt of appropriate care. Conclusions: It is possible to evaluate mental health care quality on a national basis. Most adults with a probable depressive or anxiety disorder do not receive appropriate care for their disorder. While this holds across diverse groups, appropriate care is less common in certain demographic subgroups. Published in *Archives of General Psychiatry*, v. 58, no. 1, Jan. 2001, p. 55-61.

**LRP-200102-01** Re: Surveys Identify Barriers to Participation in Clinical Trials. N. Wagle, D. P. Goldman, M. Kilgore.

Published in *Journal of the National Cancer Institute*, v. 93, no. 3, Feb. 7, 2001, p. 238–239 (Bethesda, Md.: U.S. Dept. of Health, Education, and Welfare, Public Health Service, National Institutes of Health).

**LRP-200102-02** Serving Patients Who May Die Soon and Their Families: The Role of Hospice and Other Services. J. Lynn.

The case story of a 47-year-old man with advanced rectal carcinoma illustrates the professional services and care system strategies available to help clinicians serve patients coming to the end of life. For this patient, who understands his prognosis, primary care physician services include (1) prevention and relief of symptoms, (2) assessment of each treatment before and during implementation, (3) ensuring that the patient designates a surrogate decision-maker and makes advance plans, and (4) preparation of patient and family for the time near death. Good care may entail enduring unavoidably difficult times with patients and their families. Enrollment in a hospice program requires that decision-makers confront the prognosis and their uncertainties about it, consider the desirability of other services, recognize variations among available hospice programs, address financial issues, and weigh the distress of patients and loved ones at being labeled as "dying." Hospice provides competent, continuous, and reasonably comprehensive care, but it has some constraints. Function and symptoms for those living with serious chronic illness at the end of life generally follow 1 of 3 trajectories: (a) a short period

of obvious decline at the end, which is typical of cancer; (b) long-term disability, with periodic exacerbations, and unpredictable timing of death, which characterizes dying with chronic organ system failures; or (c) self-care deficits and a slowly dwindling course to death, which usually results from frailty or dementia. Effective and reliable care for persons coming to the end of life will require changes in the organization and financing of care to match these trajectories, as well as compassionate and skillful clinicians. Published in *Journal of the American Medical Association*, v. 285, no. 7, Feb. 21, 2001, p. 925–932, 1-2.

**LRP-200102-03** Are Barriers to Mental Health and Substance Abuse Care Still Rising? R. Sturm, C. D. Sherbourne.

This study estimates unmet need and barriers to alcohol, drug, and mental health (ADM) services in 1997 to 1998 using data from a national household survey (n = 9,585). In 1997 to 1998, 10.9% of the population perceived a need for ADM services, with 15% obtaining no treatment and 11% experiencing delays or obtaining less care than needed. The rate of unmet need due to no treatment is similar to earlier studies, but the group experiencing delays/less care is almost as large. This finding emphasizes the importance of defining access to care more broadly by including timeliness and intensity of care. Economic barriers are highest for the uninsured, but also are high among the privately insured. Individuals with unmet need are significantly more likely to use complementary and alternative medicine (CAM). Those with no conventional mental health care rely on self-administered treatment, while those with delayed/insufficient conventional care use CAM providers and self-administered treatment. Published in *Journal of Behavioral Health Services and Research*, v. 28, no. 1, Feb. 2001, p. 81–88. (Thousand Oaks, Calif.: Sage Publications)

**LRP-200102-07** Needle Exchange Program Attendance and Injection Risk in Providence, Rhode Island. D. Longshore, R. N. Bluthenthal, M. Stein.

Needle sharing has long been recognized as a primary route of HIV infection. However, recent research has shown that HIV antibody is also detectable in injection supplies other than needles. In this study the authors tested frequency of attendance at a Providence, Rhode Island, needle exchange program (NEP) as a correlate of injection risk indicators including not just sharing needles but also sharing cookers, sharing cotton filters, cleaning the skin before injecting, and using bleach as a needle disinfectant. Results showed that drug users who attended the NEP less frequently were more likely to report needle sharing, less likely to report always cleaning their skin, and more likely to report sharing cookers. The Providence NEP is one at which alcohol swabs and cookers are distributed along

with clean needles. Results of this study suggest that NEPs represent a valuable and underexploited opportunity to promote risk reduction efforts beyond the avoidance of needle sharing. NEPs should be distributing risk reduction supplies in addition to clean needles and should adopt strategies (e.g., outreach and more days/hours of operation) to encourage frequent attendance. Published in *AIDS Education Prevention*, v. 13, no. 1, Feb. 2001, p. 78–90.

**LRP-200102-08** Use of Unpaid and Paid Home Care Services Among People with HIV Infection in the USA . A. S. London, J. A. Fleishman, D. P. Goldman, D. McCaffrey, S. A. Bozzette, M. F. Shapiro, A. A. Leibowitz.

This paper examines utilization of paid and unpaid home health care using data from a nationally representative sample of HIV-positive persons receiving medical care in early 1996 (N = 2,864). Overall, 21.0% used any home care, 12.2% used paid care and 13.6% used unpaid care. Most (70.0%) users of home care received care from only one type of provider. Substantially more hours of unpaid than paid care were used. They also found evidence of a strong association between type of service used and type of care provider: 62.4% of persons who used nursing services only received paid care only; conversely, 55.5% of persons who used personal care services only received care only from unpaid caregivers. Use of home care overall was concentrated among persons with AIDS: 39.5% of persons with AIDS received any home health care, compared to 9.5% of those at earlier disease stages. In addition to having an AIDS diagnosis, logistic regression analyses indicated that other need variables significantly increased utilization; a higher number of HIV-related symptoms, lower physical functioning, less energy, a diagnosis of CMV and a recent hospitalization each independently increased the odds of overall home care utilization. Sociodemographic variables had generally weak relationships with overall home care utilization. Among users of home care, non-need variables had more influence on use of paid than unpaid care. Both paid and unpaid home health care is a key component of community-based systems of care for people with HIV infection. The results presented in this paper are the first nationally representative estimates of home care utilization by persons with HIV/AIDS and are discussed with reference to policy and future research. Published in *AIDS Care*, v. 13, no. 1, Feb 2001, p. 99–121.

**LRP-200102-09** Demands of an Aging Population for Critical Care and Pulmonary Services. J. Lynn.

Published in *Journal of the American Medical Association*, v. 285, no. 8, Feb. 2001, p. 1016–1017.

**LRP-200102-11** Contraceptive Use by Couples When One Partner Is Infected with HIV. D. E. Kanouse, R. L. Collins, A. Miu, S. H. Berry.

This article is a summary of a presentation given by the authors at a conference called Microbicides 2000, held March 13–16, 2000 in Washington, D.C. The objectives of the study summarized here were (1) to ascertain the prevalence of use of specific contraceptive methods among heterosexual couples in the U.S. when at least one partner is infected with HIV, and (2) to identify demographic and attitudinal factors predicting condom use in this population. It concludes that counseling and other interventions to help HIV-positive people prevent both HIV and pregnancy may be of value. Published in *AIDS*, vol. 15, suppl. 1, Feb. 2001, p. S44–S45.

**LRP-200103-01** Expenditures for the Care of HIV-Infected Patients in the Era of Highly Active Antiretroviral Therapy. G. Joyce, D. McCaffrey, A. A. Leibowitz, S. C. Morton, S. H. Berry, A. Rastegar, D. Timberlake, M. F. Shapiro, D. P. Goldman.

**Background.** The introduction of expensive but very effective antiviral medications has led to questions about the effects on the total use of resources for the care of patients with human immunodeficiency virus (HIV) infection. The authors examined expenditures for the care of HIV-infected patients since the introduction of highly active antiretroviral therapy. **Methods.** The authors random sample of 2864 patients who were representative of all American adults receiving care for HIV infection in early 1996, and followed them for up to 36 months. They estimated the average expenditure per patient per month on the basis of self-reported information about care received. **Result.** The mean expenditure was \$1,792 per patient per month at base line, but it declined to \$1,359 for survivors in 1997, since the increases in pharmaceutical expenditures were smaller than the reductions in hospital costs. Use of highly active antiretroviral therapy was independently associated with a reduction in expenditures. After adjustments for the interview date, clinical status, and deaths, the estimated annual expenditure declined from \$20,300 per patient in 1996 to \$18,300 in 1998. Expenditures among subgroups of patients varied by a factor of as much as three. Pharmaceutical costs were lowest and hospital costs highest among underserved groups, including blacks, women, and patients without private insurance. **Conclusions.** The total cost of care for adults with HIV infection has declined since the introduction of highly active antiretroviral therapy. Expenditures have increased for medications but have declined for other services. However, there are large variations in expenditures across subgroups of patients. Published in *New England Journal of Medicine*, v. 344, no. 11, Mar 15, 2001, p. 823.

**LRP-200103-02** The Impact of State Policy on the Cost of HIV Infection. D. P. Goldman, J. Bhattacharya, A. A. Leibowitz, G. F. Joyce, M. F. Shapiro, S. A. Bozzette.

There is substantial variation in the generosity of public assistance programs that affect HIV+ patients, and these differences should affect the economic outcomes associated with HIV infection. This article uses data from a nationally representative sample of HIV+ patients to assess how differences across states in Medicaid and AIDS Drug Assistance Programs (ADAP) affect costs and labor market outcomes for HIV+ patients in care in that state. Making ADAP programs more generous in terms of drug coverage would reduce per patient total monthly costs, mainly through a reduction in hospitalization costs. In contrast, expanding ADAP eligibility by increasing the income threshold would increase the total cost of care. Expanding eligibility for Medicaid through the medically needy program would increase per patient total costs, but full-time employment would increase and so would monthly earnings. The authors conclude that more generous state policies toward HIV+ patients—especially those designed to provide access to efficacious treatment—could improve the economic outcomes associated with HIV. Published in *Medical Care Research and Review*, v. 58, no. 1, Mar. 2001, p. 31–53.

**LRP-200103-03** Use "Teachable Moments" to Save Young Lives. J. Juvonen.

Published in *Los Angeles Times*, Mar. 8, 2001.

**LRP-200103-04** A Comparison of Diabetes Patients' Self-Reported Health Status with Hemoglobin A1c Test Results in 11 California Health Plans. J. Wasserman, G. Boyce-Smith, D. S. P. Hopkins, V. Schabert, M. B. Davidson, R. J. Ozminkowski, A. Albright, S. Kennedy.

Purpose: To examine the relationship between hemoglobin A1c (HbA1c) test rates and values and various self-reported measures of health status within a sample of diabetes patients drawn from 11 California health plans, with a focus on improving diabetes care in this patient population. Design: The analysis relies on data obtained from medical records of a sample population of 4,747 diabetes patients and a patient survey mailed to a large subsample of patients included in the medical-records analysis. Methods: Descriptive methods were used to compare the medical records and survey-data results. Principal Findings: There were substantive differences noted between diabetes patients' self-reported health status, their level of satisfaction with the care they received, and the actual care they received. There was a large discrepancy between diabetes patients' perceptions of the care they received for their diabetes, which was overwhelmingly positive, and the HbA1c test-frequency

rates observed across the 11 health plans studied, which were low. Conclusions: Patients' self-reports of health status, satisfaction with care, and extent of control over diabetes—a chronic condition that may have few perceptible symptoms—are associated with significant methodological limitations. Our examination of the relationship between perceived levels of self-management of diabetes and test status indicated that for patients who had at least one HbA1c test, some education during that process may have resulted in behavioral change. Patients who received no tests, however, may remain unaware of their glycemic control and the long-term consequences associated with even mild hyperglycemia. A clear need thus exists to educate diabetes patients about their health status. Health plan and provider group investments in educational efforts aimed at increasing testing rates are likely to lead to improved glycemic control and a reduction in the incidence of diabetes related complications and related expenditures. Published in *Managed Care*, Mar. 2001, p. 58–68.

**LRP-200103-05** Utility Elicitation Using Single-Item Questions Compared with a Computerized Interview. L. A. Lenert, C. D. Sherbourne, V. Reyna.

Background. The use of a simpler procedure for the measurement of utilities could affect primarily the variance or both the mean and the variance of measurements. In the former case, simpler methods would be useful for population studies of preferences; however, in the latter, their use for such studies might be problematic. Purpose. The purpose of this study was to compare the results of utility elicitation using single-item questions to computer elicitation using the Ping-Pong search procedure. Methods. In a convenience sample of 149 primary care patients with symptoms of depression, the authors measured and compared standard gamble (SG) utilities elicited using a single-item open question to SG elicitations performed using a computerized interview procedure. Elicitations were performed 1 to 2 weeks apart to minimize memory effects. Results. More than 90% of persons with utilities of 1.0 to the single-item standard gamble had utilities of less than 1.0 on the computer SG instrument. Consistent with this finding, the mean utilities were lower in computer interviews (0.80 vs. 0.90;  $P < 0.0001$  for differences). Within subjects, utility measures had only a fair degree of correlation ( $r = 0.54$ ). Conclusions. Use of single-item questions to elicit utilities resulted in less precise estimates of utilities that were upwardly biased relative to those elicited using a more complex search procedure. Published in *Medical Decision Making*, v. 21, no. 2, Mar-Apr. 2001, p. 97–104.

**LRP-200103-07** Quality of Life Before Death for Men with Prostate Cancer: Results from the CaPSURE

Database. M. S. Litwin, D. P. Lubeck, M. L. Stoddard, D. J. Pasta, S. C. Flanders, J. M. Henning.

**Purpose:** The authors examined changes in health related quality of life during the 12 months before death in men with prostate cancer. **Materials and Methods:** They studied patients from CapSure, which is a longitudinal observational cohort of men with biopsy proved prostate cancer treated in community and academic urology practices across the United States. Of all men in the cohort who died while being followed for prostate cancer 131 who had submitted health related quality of life surveys during the 6 months before death were included in this analysis. Health related quality of life was measured with the RAND 36-Item Health Survey, an established validated instrument that comprises 4 physical and 4 mental domains. **Results:** On univariate analysis all 8 domains of the 36-Item Health Survey substantially decreased in the final year of life. On multivariate analysis only physical function decreased more rapidly in men dying of prostate cancer compared to those dying of other cancer or benign causes. **Conclusions:** Quality of life begins a steady and inexorable decline in the final 12 months of life in men with prostate cancer. Increased attention to quality of life changes may provide new clinical opportunities to enhance quality of care in the final year of life in these men. Published in *The Journal of Urology*, v. 165, no. 3, Mar. 2001, p. 871–875.

**LRP-200104-01** Fidelity, Adherence and Robustness of Interventions. N. Duan, J. T. Braslow, J. R. Weisz, K. B. Wells.

Published in *Psychiatric Services*, v. 52, no. 4, Apr. 2001, p. 413.

**LRP-200104-02** The Role of Computer Use in Different Medical Specialties. R. Sturm.

Published in *Psychiatric Services*, v. 52, no. 4, Apr. 2001, p. 443.

**LRP-200104-03** Does Physician Gender Affect Satisfaction of Men and Women Visiting the Emergency Department? K. P. Derose, R. D. Hays, D. McCaffrey, D. Baker.

**Objective:** To assess the association of physician gender with patient ratings of physician care. **DESIGN:** Interviewer-administered survey and follow-up interviews 1 week after emergency department (ED) visit. **Setting:** Public hospital ED. **Patients/Participants:** English and Spanish speaking adults presenting for care of non-emergent problems; of 852 patients interviewed in the ED who were eligible for follow-up, 727 (85%) completed a second interview. **Measurements and Main Results:** The authors conducted separate ordered logistic regressions for women and men to determine the unique association of

physician gender with patient ratings of 5 interpersonal aspects of care, their trust of the physician, and their overall ratings of the physician, controlling for patient age, health status, language and interpreter status, literacy level, and expected satisfaction. Female patients trusted female physicians more ( $P = .003$ ) than male physicians and rated female physicians more positively on the amount of time spent ( $P = .01$ ), on concern shown ( $P = .04$ ), and overall ( $P = .03$ ). Differences in ratings by female patients of male and female physicians in terms of friendliness ( $P = .13$ ), respect shown ( $P = .74$ ), and the extent to which the physician made them feel comfortable ( $P = .10$ ) did not differ significantly. Male patients rated male and female physicians similarly on all dimensions of care (overall,  $P = .74$ ; friendliness,  $P = .75$ ; time spent,  $P = .30$ ; concern shown,  $P = .62$ ; making them feel comfortable,  $P = .75$ ; respect shown,  $P = .13$ ; trust,  $P = .92$ ). **Conclusions:** Having a female physician was positively associated with women's satisfaction, but physician gender was not associated with men's satisfaction. Further studies are needed to identify reasons for physician gender differences in interpersonal care delivered to women. Published in *Journal of General Internal Medicine*, v. 16, no. 4, Apr. 2001, p. 218–226.

**LRP-200104-06** Stress in Caregivers of Hospitalized Oldest-Old Patients. N. A. Desbiens, N. Rizner-Mueller, B. Virnig, J. Lynn.

**BACKGROUND:** Stress in caregivers of elderly patients is a well-recognized health care problem. However, little has been published about the stress in caregivers of the oldest-old patients, the most rapidly growing segment of our population. **METHODS:** A prospective cohort study was conducted in four teaching hospitals. Questionnaires were administered to patients 80 years of age and older and their surrogates (the person who would make decisions if the patient were unable to—usually a family member) who identified themselves as the primary caregivers for the patients. Data were abstracted from medical records. **RESULTS:** Caregivers tended to be female and 50 years of age or older. About one in five described her own health as fair or poor; nearly half of them lived with the patient. About one quarter spent at least 8 h/d caring for the patient, and they had few persons available to help them with care. Most of the caregivers reported mild-to-moderate levels of stress. After adjustment, higher stress scores were associated with female caregivers, poorer caregiver health, more hours per day spent caring for the patient, and the presence of patient depression and hearing impairment. **CONCLUSION:** Stress is common in caregivers of the hospitalized oldest-old patients. Women who are in poor health and spend 8 or more hours every day caring for relatives aged 80 and over are at high risk for caregiver stress. Treatment of patient depression and hearing impairment may ameliorate

caregiver stress. Published in *Journal of Gerontology: Medical Sciences*, v. 56A, no. 4, Apr. 2001, p. M231–235.

**LRP-200104-07** If Daily Dialysis Is the Answer, What Is the Question? R. A. Rettig.

This paper argues that the case for daily dialysis must be made unequivocally on the grounds of clinical effectiveness, patient preferences, and disaggregated costs and benefits. Published in *American Journal of Kidney Disease*, v. 37, no. 4, Apr. 2001, p. 862–865.

**LRP-200104-08** How Will Family Physicians Care for the Patient in the Context of Family and Community? L. M. Candib, L. Gelberg.

Difficulties caring for patients in the context of family and community stem from problems of power and vulnerability. Patients are disempowered in relation to physicians and to the medical care system. Physicians are disempowered in their ability to provide comprehensive relationship-centered care to individuals and families because of economic constraints on medical care and limits on continuity of care. Individual patients are also vulnerable to abuses of power within their families because of physical and sexual abuse; the recognition of such abuses and appropriate interventions for them requires awareness of the gender ideology that underlies interpersonal abuses of power. Families and communities can be disempowered because of vulnerabilities related to race, ethnicity, poverty, and homelessness. The additive effects of these vulnerabilities have created health disparities that are a hallmark of inequities in our country's medical system. Opportunities to teach students to recognize and address these disparities abound within medical education. Participatory training and educational action projects can prepare learners to lead us toward a more just and egalitarian medical system with the potential to change the context of family and community in which we care for patients. However, systematic commitment from educational programs is necessary to produce activated clinicians, teachers, and researchers to achieve these changes. Published in *Family Medicine*, v. 33, no. 4, Apr. 2001, p. 298–310.

**LRP-200104-09** Are Aggressive Treatment Strategies Less Cost-Effective for Older Patients? M. B. Hamel, R. S. Phillips, R. B. Davis, J. Teno, N. Desbiens, J. Lynn, J. Tsevat.

**OBJECTIVES:** A common assumption is that life-sustaining treatments are much less cost-effective for older patients than for younger patients. The author estimated the incremental cost-effectiveness of providing mechanical ventilation and intensive care for patients of various ages who had acute respiratory failure. **DESIGN:** Retrospective analysis of data on acute respiratory failure from Study to

Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT). **SETTING:** Acute hospital. **PARTICIPANTS:** 1,005 with acute respiratory failure; 963 received ventilator support and 42 had ventilator support withheld. **MEASUREMENTS:** The authors studied 1,005 patients enrolled in a five-center study of seriously ill patients (SUPPORT) with acute respiratory failure (pneumonia or acute respiratory distress syndrome and an Acute Physiology Score  $\geq$  10) requiring ventilator support. For cost-effectiveness analyses, they estimated life expectancy based on long-term follow-up of SUPPORT patients and estimated utilities (quality-of-life weights) using time-tradeoff questions. The authors used hospital fiscal data and Medicare data to estimate healthcare costs. The authors divided patients into three age groups ( $<$  65, 65–74, and  $>$  or  $=$  75 years); for each age group, they performed separate analyses for patients with a  $<$  or  $=$  50% probability of surviving at least 2 months (high-risk group) and those with a  $>$  50% probability of surviving at least 2 months (low-risk group). **RESULTS:** Of the 963 patients who received ventilator support, 44% were female; 48% survived 6 months; and the median (25th, 75th percentile) age was 63 (46, 75) years. For the 42 patients for whom ventilator support was withheld, the median survival was 3 days. For low-risk patients ( $>$  50% estimated 2-month survival), the incremental cost (1998 dollars) per quality-adjusted life-year (QALY) saved by providing ventilator support and aggressive care increased across the three age groups (\$32,000 for patients age  $<$  65, \$44,000 for those age 65–74, and \$46,000 for those age  $>$  or  $=$  75). For high-risk patients, the incremental cost-effectiveness was much less favorable and was least favorable for younger patients (\$130,000 for patients age  $<$  65, \$100,000 for those age 65–74, and \$96,000 for those age  $>$  or  $=$  75). When we varied our assumptions from 50% to 200% of our baseline estimates in sensitivity analyses, results were most sensitive to the costs of the index hospitalization. **CONCLUSIONS:** For patients with relatively good short-term prognoses, we found that ventilator support and aggressive care were economically worthwhile, even for patients 75 years and older. For patients with poor short-term prognoses, ventilator support and aggressive care were much less cost-effective for adults of all ages. Published in *Journal of the American Geriatrics Society*, v. 49, no. 4, Apr. 2001, p. 382–390.

**LRP-200105-01** Factors Associated with Readiness to Change Drug Use Among Needle-Exchange Users. R. N. Bluthenthal, A. Gogineni, D. Longshore, M. Stein.

To determine if frequent needle-exchange program (NEP) use is associated with lower readiness to change drug use, NEP clients in Providence, RI were interviewed regarding their drug use, HIV risk, health, and past use of drug treatment services in 1997–1998. Readiness to change

drug use was assessed using a nine-step decision ladder. Based on this assessment, 14.3% of the sample were classified as precontemplators (24/168), 29.2% were in the contemplation stage (49/168), and 56.5% were in the determination or ready to change stage (95/168). The authors found that mean number of NEP visits was 25.5 among precontemplators, 28.7 among contemplators, and 22.5 among those in the determination stage. In multivariate analysis, an inverse relationship between having ever been in alcohol treatment and higher readiness to change drug use was the only significant association. In this exploratory study, the authors found that more frequent NEP participation did not impact readiness to change drug use among intravenous drug users. Given the high proportion of NEP clients ready to change drug use, improving linkages between NEPs and substance abuse treatment appears warranted. Published in *Drug and Alcohol Dependence*, v. 62, no. 3, May 2001, p. 225-230.

**LRP-200105-02** Effect of Specialty and Nationality on Panel Judgments of the Appropriateness of Coronary Revascularization: A Pilot Study. S. Bernstein, P. Lazaro, K. Fitch, M. D. Aguilar, J. P. Kahan.

Background: Appropriateness criteria are frequently used to assess quality of care. However, assessing care in one country with criteria developed in another may be misleading. One approach to measuring care across countries would be to develop common standards using physicians from different countries and specialties. Objective: To identify the degree to which appropriateness ratings for coronary revascularization developed by a multinational panel differ by panelist specialty and nationality. Methods: A 13-member panel of cardiothoracic surgeons and cardiologists from the Netherlands, Spain, Sweden, Switzerland, and the United Kingdom was convened to rate the appropriateness of 842 indications for percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass graft surgery (CABG) on a 1 (extremely inappropriate) to 9 (extremely appropriate) scale. Measures: Mean appropriateness ratings by panelist specialty and nationality. Results: Surgeons' mean ratings for PTCA indications ranged from 0.64 points lower than the corresponding ratings of the cardiologists for acute myocardial infarction indications to 1.22 points lower for chronic stable angina indications. Conversely, their ratings for bypass surgery indications ranged from 0.59 points higher for chronic stable angina indications to 0.69 points higher for unstable angina indications. Although Spanish panelists' ratings were significantly higher than the mean for 3 of the 4 clinical conditions treated by PTCA, their ratings were similar for bypass surgery indications. No specific patterns were observed in the ratings of the panelists from the other countries. Conclusions: These findings support the use of physicians from multiple

specialties on appropriateness panels because they represent more divergent views than physicians from a single specialty. Finding no systematic difference in beliefs regarding the appropriateness of PTCA and CABG among physicians from different countries will require confirmation before multinational panels supplant single country panels in future studies. Published in *Medical Care*, v. 39, no. 5, May 2001, p. 513-520.

**LRP-200105-03** Providing Care at the End of Life, Do Medicare Rules Impede Good Care? A Study of End-of-Life Care Providers Reveals Some Shortcomings. H. A. Huskamp, M. B. Buntin, V. Wang, J. P. Newhouse.

Medicare spends more than a quarter of its annual budget on care for those in their last year of life and covers more than 80 percent of decedents. Studies have documented poor quality of care, gaps in care, and patient and family dissatisfaction with care received by dying patients. Nineteen percent of Medicare decedents, nearly 360,000 beneficiaries, used the Medicare hospice benefit in 1998. In recent years we have heard providers report anecdotes about cases in which Medicare coverage and reimbursement rules may have impeded the delivery of high-quality end-of-life care to terminally ill Medicare beneficiaries. Among these anecdotes are that (1) skilled nursing facilities (SNFS) are transferring dying patients to hospitals in part so that the SNF does not incur the costs of the intensive treatments that the patients might need, (2) hospitals are discharging dying patients in response to diagnosis-related group (DRG) payment incentives; (3) patients are being dissuaded from electing hospice if they need particularly high-cost palliative care; (4) hospices and home health agencies are avoiding patients without caregivers in the home or with high levels of need for home care; and (5) physicians are not referring patients (particularly noncancer patients) to hospice because they fear that they will be charged with fraud if the referred patients do not die within six months. No information has been systematically gathered about the extent to which Medicare coverage and reimbursement methods have affected care or how widespread these issues may be. In this study the authors assess problems faced by several types of providers delivering end-of-life services under fee-for-service (FFS) Medicare. The authors identify important ways in which Medicare benefit design and financing rules both facilitate and create barriers to effective end-of-life care. Published in *Health Affairs*, v. 20, no. 3, May-June 2001, p. 204-211.

**LRP-200105-04** A New Approach for Measuring Quality of Care for Women with Hypertension. S. M. Asch, E. A. Kerr, P. Lapuerta, A. V. Law, E. A. McGlynn.

Background: Guidelines for care of hypertensive patients have proliferated recently, yet quality assessment remains difficult in the absence of well-defined measurement

systems. Existing systems have not always linked process measures to blood pressure outcomes. Methods: A quality measurement system was developed and tested on hypertensive women in a West Coast health plan. An expert panel selected clinically detailed, evidence-explicit indicators using a modified Delphi method. Thirteen indicators (1 screening, 5 diagnostic, 5 treatment, and 2 follow-up indicators) were selected by this process. Trained nurses used a laptop based tool to abstract data from medical records for the most recent 2 years of care. Results: Of 15 004 eligible patients with hypertensive and other chronic disease codes, 613 patients were sampled, all eligible for the screening indicator. Of these, 234 women with an average blood pressure of 140/90 mm Hg or more, or a documented diagnosis of hypertension, were studied for the remaining indicators. The average woman received 64% of the recommended care. Most patients did not receive adequate initial history, physical examination, or laboratory tests. Only 37% of hypertensive women with persistent elevations to more than 160/90 mm Hg had changes in therapy or lifestyle recommended. The average adherence proportion to all indicators was lower in patients with uncontrolled blood pressure (>140/90 mm Hg) than in those with controlled blood pressure (54% vs 73%;  $P < .001$ ). Conclusions: Quality of hypertensive care falls short of indicators based on randomized controlled trials and national guidelines. Poor performance in essential care processes is associated with poor blood pressure control. Published in *Archives of Internal Medicine*, v. 161, no. 10, May 28, 2001, p. 1329–1335.

**LRP-200105-05** The Health and Mental Health of Disabled Substance Abusers. K. E. Watkins, D. Podus, E. Lombardi.

In 1996 Congress terminated Supplemental Security Income (SSI) benefits to individuals disabled by substance abuse. Although most were expected to continue benefits under another disability category, 64% were not reclassified. This article examines data from a longitudinal study of individuals in Los Angeles County affected by the legislation. While poor physical health predicted both continued SSI benefits and receipt of public income assistance, many individuals reporting significant mental and physical health problems were not reclassified and did not receive public income assistance, raising concern for their welfare. Local safety nets may become increasingly important for this population. Published in *Journal of Behavioral Health Services Research*, v. 28, no. 2, May 2001, p. 205–211.

**LRP-200105-06** Sexual Transmission of HIV-1 Among Injection Drug Users in San Francisco, USA: Risk-Factor Analysis. A. H. Kral, R. N. Bluthenthal, J. Lorvick, L. Gee, P. Bacchetti, B. R. Edlin.

Background: Many new HIV-1 infections in the USA occur in injection drug users (IDUs). HIV-1 seroconversion of IDUs is mainly associated with injection-related risk factors. Harm reduction programmes concentrate on injection-risk behaviour. The authors aimed to establish whether injection or sexual risk factors, or both, were associated with HIV-1 antibody seroconversion of street-recruited IDUs in San Francisco, from 1986 to 1998. Methods: IDUs were enrolled every 6 months from four community sites. The authors did a nested case control study comparing 58 respondents who seroconverted between visits with 1134 controls who remained seronegative. Controls were matched with cases by sex and date. Adjusted odds ratios and 95% CI were calculated for men and women by use of conditional logistic regression. Findings: Men who had sex with men were 8.8 times as likely to seroconvert (95% CI 3.7–20.5) as heterosexual men. Women who reported having traded sex for money in the past year were 5.1 times as likely as others to seroconvert (95% CI 1.9–13.7). Women younger than 40 years were more likely to seroconvert than those 40 years or older (2.8 1.05–7.6), and women who reported having a steady sex-partner who injected drugs were less likely to seroconvert than other women (0.32 0.11–0.92). Interpretation: HIV-1 seroconversion of street-recruited IDUs in San Francisco is strongly associated with sexual behaviour. HIV-1 risk might be reduced by incorporation of innovative sexual-risk-reduction strategies into harm-reduction programmes. Published in *The Lancet*, v. 357, May 5, 2001, p. 1397–1401.

**LRP-200105-07** Planning Medical Services for the End of Life: Letter to the Editor. J. Lynn.

Published in *JAMA, Journal of the American Medical Association*, v. 285, no. 20, May 23/30, 2001, p. 2578–2579.

**LRP-200105-08** Psychological Distress, Unmet Need, and Barriers to Mental Health Care for Women. M. Dwight-Johnson, R. Klap.

Using data from the Commonwealth Fund 1998 Survey of Women's Health, this article describes the characteristics of women in need of mental health services for depression or anxiety, and identifies factors related to why women do not get needed care. Depressive/anxiety symptoms are common and access to care for psychological distress remains a problem for many women, especially for minorities, those with less education, and those without a usual source of health care. Sources of unmet need include patient factors, clinician factors, and characteristics of the health system, such as costs of mental health care. Published in *Women's Health Issues*, v. 11, no. 3, May-Jun. 2001, p. 231–243.

**LRP-200105-09** Sex Differences in Predictors of Adolescent Smoking Cessation. P. L. Ellickson, J. S. Tucker, D. J. Klein.

Sex differences in predictors of smoking cessation were investigated among 337 male and 490 female participants in the RAND adolescent panel study. Participants reported smoking at least 11–20 times during the past year at Grade 10, with cessation defined as not smoking during the past year at Grade 12. Controlling for demographics, sex-specific analyses indicated that girls who quit smoking within 2 years had friends who smoked less frequently, perceived less parental approval of their smoking, had weaker intentions to continue smoking, used marijuana less frequently, attended fewer different schools, were more likely to have an intact nuclear family, experienced greater peer support, and rated themselves as healthier. Similar analyses for boys yielded results that were generally weaker and nonsignificant, with smoking quantity accounting for several associations in the sex-specific models. Despite these differences, interaction tests revealed significant sex differences for only three predictors. Implications of these results for understanding adolescent smoking cessation are discussed. Published in *Health Psychology*, v. 20, no. 3, May 2001, p. 186-195.

**LRP-200105-10** Associations of Symptoms and Health-Related Quality of Life: Findings from a National Study of Persons with HIV Infection. K. A. Lorenz, M. F. Shapiro, S. M. Asch, S. A. Bozzette, R. D. Hays.

**BACKGROUND:** Health-related quality of life refers to how well people are able to perform daily activities (functioning) and how they feel about their lives (well-being). The relationship between symptoms and health-related quality of life has not been fully explored. **OBJECTIVE:** To estimate the association of HIV symptoms with health-related quality of life and with disability days. **DESIGN:** Prospective cohort study. **SETTING:** HIV providers in 28 urban and 24 rural randomly selected sites throughout the United States. **PATIENTS:** Nationally representative sample of 2267 adults with known HIV infection who were interviewed in 1996 and again between 1997 and 1998. **MEASUREMENTS:** Symptoms, two single-item global measures of health-related quality of life (perceived health and perceived quality of life), and disability days. **RESULTS:** White patches in the mouth; nausea or loss of appetite; persistent cough, difficulty breathing, or difficulty catching one's breath; and weight loss were associated with more disability days and worse scores on both health-related quality-of-life measures. Headache; pain in the mouth, lips, or gums; dry mouth; and sinus infection, pain, or discharge were associated with worse perceived health. Pain in the mouth, lips, or gums; trouble with eyes; pain, numbness, or tingling of hands or feet; and diarrhea or loose or watery stools were associated with

worse perceived quality of life. Headache and fever, sweats, or chills were associated with more disability days. **CONCLUSIONS:** Several symptoms are associated with worse health-related quality of life and more disability days in persons with HIV infection. In such patients, targeting specific symptoms may improve health-related quality of life and reduce disability. Published in *Annals of Internal Medicine*, v. 134, no. 9, part 2, May 1, 2001, p. 854–860.

**LRP-200105-11** Use of Contraceptive Methods Among Homeless Women for Protection Against Unwanted Pregnancies and Sexually Transmitted Diseases: Prior Use and Willingness to Use in the Future.

Lifetime contraceptive use as reported by a representative sample of 764 homeless women in Los Angeles was examined overall and for different age and ethnic subgroups and contrasted with expressed willingness to use specific methods. Over 80% of the women reported condom use. However, less than 5% had ever used female condoms, although 38% of the overall sample and 73% of the teenagers said they were willing to try them. Similar gaps between reported use and endorsement were found for other particular methods. Native Americans had relatively low use of virtually all contraceptive methods, and over 80% of African-Americans rejected implants. Our findings suggested that age-related factors and ethnocultural perceptions may deter some homeless women from using contraception. In any case, gaps between realized use and willingness to use may represent missed opportunities to prevent the high rates of unintended pregnancies and sexually transmitted infections found among homeless women. Published in *Contraception*, v. 63, no. 5, May 2001, p. 227-281.

**LRP-200105-12** Assessing Use of Primary Health Care Services by Very Low-Income Adults in a Managed Care Program.

**OBJECTIVE:** To assess the effect of providing free health care services to low-income adults. **METHODS:** We measured access to primary care services by enrollees with 4 chronic medical conditions in the General Relief Health Care Program (GRHCP), a program designed for adults receiving General Relief (GR). Implemented by the Los Angeles County Health Department in October 1995, the GRHCP is composed of private and public health care facilities. As adults registered for GR, they were asked to complete a baseline health survey, were enrolled in the GRHCP, and assigned a health care provider. A total of 8520 surveys were completed between September and November 1996 (98% response rate). The analyses of this article are limited to individuals (N = 2164) who reported a history of hypertension, diabetes mellitus, a nonresolving cough, or substance dependence. We reviewed medical records to determine whether new GR recipients had

visited their designated GRHCP provider within 4 months of enrollment and used multivariate logistic regression to assess the effect of individual patient factors on the use of free health care. **RESULTS:** A total of 17% of individuals visited their assigned GRHCP provider within 4 months of enrollment. In multivariate analysis, patients were more likely to have made a visit if they were younger than 50 years, were female, were Asian/Pacific Islander, reported needing to see a physician, or had seen a physician within 12 months. **CONCLUSIONS:** It is not sufficient to merely supply the name and address of a health care provider to this population. More aggressive efforts should be attempted to increase utilization of services for patients with medical conditions responsive to ambulatory care. Published in *Archives of Internal Medicine*, v. 161, no. 9, May 14, 2001, p. 1222–1227.

**LRP-200105-14** "Serious and Complex Illness" in Quality Improvement and Policy Reform for End-of-Life Care. J. Lynn, J. H. Forlini.

Americans are living longer - a mark of success in public health and medical care - but more will live the last few years with progressive illness and disability. The dominant conception of care delivery separates "aggressive" or life-extending care from "palliative" or death-accepting care, with an assumed "transition" between them. The physiology and the experience of this population are mismatched in this model. Here, the author propose a more useful category for public policy and clinical quality improvement: persons who will die as a result of "serious and complex illness." Delivery system changes could ensure reliable, continuous, and competent care to this population. Published in *Journal of General Internal Medicine*, v. 16, no. 5, May 2001, p. 315–319.

**LRP-200105-15** Violence Exposure Among School-Age Children in Foster Care: Relationship to Distress Symptoms. B. D. Stein, B. Zima, M. N. Elliott, M. A. Burnam, A. Shahinfar, N. A. Fox, L. A. Leavitt.

**OBJECTIVE:** To describe the amount and nature of violence exposure and examine the relationship between violence exposure and distress symptoms among children in foster care. **METHOD:** Violence exposure and distress symptoms were evaluated in interviews, conducted between July 1996 and March 1998, of 300 children from Los Angeles County living in out-of-home placement. **RESULTS:** Interviews were successfully completed in 91% of eligible children. The majority of children (85%) reported having been a witness to violence, and 51% had been a victim of violence during their lifetime. Of these youths, 54% and 41%, respectively, reported having been exposed to such violence in the past 6 months. Girls, victims of assaultive violence and weapon related violence, and those reporting exposure to mild violence were more likely ( $p < .05$ ) to have higher levels of distress

symptoms than those without such characteristics, after age was controlled for. **CONCLUSIONS:** Children in foster care continue to have high levels of violence exposure, even after removal from their biological parents' home. The relationship between violence exposure and distress symptoms underscores the need for clinicians to inquire about multiple forms of violence exposure among children living in out-of-home placement. Published in *Journal of American Academy of Child and Adolescent Psychiatry*, v. 40, no. 5, May 2001, p. 588–594.

**LRP-200106-01** End-of-Life Discussions and Preferences Among Persons with HIV. N. S. Wenger, D. E. Kanouse, R. L. Collins, L. Honghu, M. A. Schuster, A. L. Gifford, S. A. Bozzette, M. F. Shapiro.

**Context.** Deficits in advance care planning leave many patients and their physicians unprepared for decisions about end-of-life care. Even though the prognosis has improved for many persons with human immunodeficiency virus (HIV) infection, a need for planning remains. **Objective.** To evaluate prevalence of end-of-life discussions, use of advance directives, and preferences concerning end-of-life care and their relationship with patient demographics, clinical status, psychosocial variables, and practitioner characteristics among HIV-infected persons. **Design, Setting, and Patients.** Cross-sectional survey of a US probability sample of 2864, which represents 231400 adults receiving care for HIV, conducted from January 1996 to April 1997. **Main Outcome Measures.** Communication with physician regarding end-of-life issues, completion of an advance directive, preference for aggressiveness of care, and willingness to tolerate future permanent adverse health states. **Results.** A total of 1432 patients (50%) discussed some aspect of end-of-life care with their practitioner and 1088 (38%) completed an advance directive. Patients were more likely to complete an advance directive after a physician discussion (odds ratio *OR* 5.82; 95% confidence interval *CI* 4.50–7.52). Practitioners discussed end-of-life care less with blacks (*OR*, 0.57; 95% *CI*, 0.39–0.83) and Latinos (*OR*, 0.74; 95% *CI*, 0.55–0.98) than with whites. Women (*OR*, 1.39; 95% *CI*, 1.05–1.84) and patients with children in the household (*OR*, 1.53; 95% *CI*, 1.12–2.10) communicated the most with practitioners about end-of-life issues. Patients infected with HIV via injection drug use (*OR*, 0.64; 95% *CI*, 0.45–0.89) and those with less education communicated the least with physicians about end-of-life issues. Less denial, greater trust in one's practitioner, and longer patient-practitioner relationship were associated with more advance care planning. **Conclusions.** Half of all persons infected with HIV are at risk of making end-of-life decisions without prior discussions with their health care practitioners. Blacks, Latinos, intravenous drug users, and less educated individuals need advance care planning interventions in

clinical HIV programs. Published in *JAMA, Journal of the American Medical Association*, v. 285, no. 22, Jun. 13, 2001, p. 2880-2890.

**LRP-200107-03** Differences in CAHPS Adult Survey Reports and Ratings by Race and Ethnicity: An Analysis of the National CAHPS Benchmarking Data 1.0. L. S. Morales, M. N. Elliott, R. Weech-Maldonado, K. L. Spritzer, R. D. Hays.

**Objective.** To examine racial/ethnic group differences in adults' reports and ratings of care using data from the National Consumer Assessment of Health Plans (CAHPS) survey Benchmarking Database (NCBD) 1.0. **Data Source.** Adult data from the NCBD 1.0 is comprised of CAHPS 1.0 survey data from 54 commercial and 31 Medicaid health plans from across the United States. A total of 28,354 adult respondents (age > 18 years) were included in this study. Respondents were categorized as belonging to one of the following racial/ethnic groups: Hispanic (n = 1,657), white (n = 20,414), black or African American (n = 2,942), Asian and Pacific Islander (n = 976), and American Indian or Alaskan native (n = 588). **Study Design.** Four single-item global ratings (personal doctor, specialty care, overall rating of health plan, and overall rating of health care) and five multiple-item report composites (access to needed care, provider communication, office staff helpfulness, promptness of care, and health plan customer service) from CAHPS 1.0 were examined. **Statistical Analyses.** Multiple regression models were estimated to assess differences in global ratings and report composites between whites and members of other racial/ethnic groups, controlling for age, gender, perceived health status, educational attainment, and insurance type. **Principal Findings.** Members of racial/ethnic minority groups, with the exception of Asians/Pacific Islanders, reported experiences with health care similar to those of whites. However, global ratings of care by Asians/Pacific Islanders are similar to those of whites. **Conclusions.** Improvements in quality of care for Asians/Pacific Islanders are needed. Comparisons of care in racially and ethnically diverse populations based on global ratings of care should be interpreted cautiously. Originally published in *HSR, Health Services Research*, v. 36, no. 3, Jul. 2001, p. 595-617.

**LRP-200107-04** The Role of Performance Measures for Improving Quality in Managed Care Organizations. D. P. Scanlon, C. Darby, E. S. Rolph, H. E. Doty.

**Objectives.** To understand how managed care plans use performance measures for quality improvement and to identify the strengths and weaknesses of currently used standardized performance measures such as the Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plans (CAHPS) survey. **Data Sources/Study Setting.** Representatives (chief

executive officers, medical directors, and quality-improvement directors) from 24 health plans in four states were surveyed. The overall response rate was 58.3 percent, with a mean of 1.8 respondents per plan. **Study Design.** This exploratory qualitative research used a purposive sample of respondents. Two study authors conducted separate one-hour tape-recorded telephone interviews with multiple respondents from each health plan. **Principal Findings.** All managed care organizations interviewed use performance measures for quality improvement but the degree and sophistication of use varies. Many of our respondent plans use performance measures to target quality-improvement initiatives, evaluate current performance, establish goals for quality improvement, identify the root cause of problems, and monitor performance. **Conclusion.** Performance measures are used for quality improvement in addition to informing external constituents, but additional research is needed to understand how the benefits of measurement can be maximized. Published in *HSR, Health Services Research*, v. 36, no. 3, July 2001, p. 619-641.

**LRP-200107-05** Racial and Ethnic Differences in Parents' Assessments of Pediatric Care in Medicaid Managed Care. R. Weech-Maldonado, L. S. Morales, K. L. Spritzer, M. N. Elliott, R. D. Hays.

**Objective.** This study examines whether parents' reports and ratings of pediatric health care vary by race/ethnicity and language in Medicaid managed care. **Data Sources.** The data analyzed are from the National Consumer Assessment of Health Plans (CAHPS) Benchmarking Database 1.0 and consist of 9,540 children enrolled in Medicaid managed care plans in Arkansas, Kansas, Minnesota, Oklahoma, Vermont, and Washington state from 1997 to 1998. **Data Collection.** The data were collected by telephone and mail, and surveys were administered in Spanish and English. The mean response rate for all plans was 42.1 percent. **Study Design.** Data were analyzed using multiple regression models. The dependent variables are CAHPS 1.0 ratings (personal doctor, specialist, health care, health plan) and reports of care (getting needed care, timeliness of care, provider communication, staff helpfulness, plan service). The independent variables are race/ethnicity (white, African American, American Indian, Asian, and Hispanic), Hispanic language (English or Spanish), and Asian language (English or other), controlling for gender, age, education, and health status. **Principal Findings.** Racial/ethnic minorities had worse reports of care than whites. Among Hispanics and Asians language barriers had a larger negative effect on reports of care than race/ethnicity. For example, while Asian non-English-speakers had lower scores than whites for staff helpfulness (B = -20.10), timeliness of care (B = -18.65), provider communication (B = -17.19), plan service (B = -10.95),

and getting needed care ( $B = -8.11$ ), Asian English speakers did not differ significantly from whites on any of the reports of care. However, lower reports of care for racial/ethnic groups did not translate necessarily into lower ratings of care. Conclusions. Health plans need to pay increased attention to racial/ethnic differences in assessments of care. This study's finding that language barriers are largely responsible for racial/ethnic disparities in care suggests that linguistically appropriate health care services are needed to address these gaps. Published in *HSR, Health Services Research*, v. 36, no. 3, July 2001, p. 575-594.

**LRP-200107-08** Fertility Desires and Intentions of HIV-Positive Men and Women. J. L. Chen, K. A. Phillips, D. E. Kanouse, R. L. Collins, A. Miu.

CONTEXT: HIV-positive men and women may have fertility desires and may intend to have children. The extent of these desires and intentions and how they may vary by individuals' social and demographic characteristics and health factors is not well understood. METHODS: Interviews were conducted from September through December 1998 with 1,421 HIV-infected adults who were part of the HIV Cost and Services Utilization Study, a nationally representative probability sample of 2,864 HIV-infected adults who were receiving medical care within the contiguous United States in early 1996. RESULTS: Overall, 28-29% of HIV-infected men and women receiving medical care in the United States desire children in the future. Among those desiring children, 69% of women and 59% of men actually expect to have one or more children in the future. The proportion of HIV-infected women desiring a child in the future is somewhat lower than the overall proportion of U.S. women who desire a child. The fertility desires of HIV-infected individuals do not always agree with those of their partners: As many as 20% of HIV-positive men who desire children have a partner who does not. Generally, HIV-positive individuals who desire children are younger, have fewer children and report higher ratings of their physical functioning or overall health than their counterparts who do not desire children, yet desire for future childbearing is not related to measures of HIV progression. HIV-positive individuals who expect children are generally younger and less likely to be married than those who do not. Multivariate analyses indicate that black HIV-positive individuals are more likely to expect children in the future than are others. While HIV-positive women who already have children are significantly less likely than others both to desire and to expect more births, partner's HIV status has mixed effects: Women whose partner's HIV status is known are significantly less likely to desire children but are significantly more likely to expect children in the future than are women whose partner's HIV status is unknown. Moreover, personal health status

significantly affects women's desire for children in the future but not men's, while health status more strongly influences men's expectations to have children. CONCLUSIONS: The fact that many HIV-infected adults desire and expect to have children has important implications for the prevention of vertical and heterosexual transmission of HIV, the need for counseling to facilitate informed decision-making about childbearing and childrearing, and the future demand for social services for children born to infected parents. Published in *Family Planning Perspectives*, v. 33, no. 4, July/Aug. 2001, p.144-152, 165.

**LRP-200107-09** Hepatitis B Among Homeless and Other Impoverished US Military Veterans in Residential Care in Los Angeles Health of Homeless Adults in Los Angeles. L. Gelberg, M. J. Robertson, B. Leake, S. L. Wenzel, L. Bakhtiar, E. A. Hardie, T. Getzug.

Findings are presented for a cross-sectional study of serological markers of hepatitis B virus (HBV) infection in an underserved population of impoverished veterans of the US armed forces in a Veterans Administration (VA) residential program in the US. The authors examine the demographic, background, and risk factors associated with HBV infection in this high-risk population. This paper presents a secondary analysis of cross-sectional survey and clinical data for 370 male veterans who were residents of a domiciliary care program for homeless veterans in Los Angeles, using Fisher\_ga\_ss Exact, and logistic regression analysis. About one-third (30.8% of the sample tested positive for current or past HBV infection (ie, seropositive for either the HBV core antibody or surface antigen). After multivariate analysis, rates of HBV were significantly higher among veterans who were older, non-white, or who had a history of regular heroin use (a proxy measure for injection drug use), drug overdose, or drug detoxification treatment. The rate of current or past HBV infection among veterans in this sample (30.8%) was high compared to an estimates 5% to 8% of the general US population. Also, 3% of the sample were currently infected with HBV. Strategies for intervention include broader screening, immunization, and treatment interventions with this high-risk group. Published in *Public Health*, v. 115, no. 4, Jul. 2001, p. 286 291.

**LRP-200107-10** The NIH Consensus Conference on Diagnosis, Treatment and Management of Dental Caries Throughout Life: Process and Outcome. I. D. Coulter.

In attempting to develop evidenced-based practice, the health professions face several challenges. The first is simply trying to ensure that providers are aware of good scientific evidence derived from research, and the second is to determine what constitutes good evidence. Here the gold standard is the randomized, double-blind, placebo-controlled trial. But a hierarchy of evidence has been

established, ranging from the randomized controlled trial to the controlled trial to cohort studies to case series to case studies. Published in *Journal of Evidence-Based Dental Practice*, v. 1, no. 1, Jul. 2001, p-58–63.

**LRP-200107-11** Assessing Symptoms Before Hysterectomy: Is the Medical Record Accurate? . M. S. Broder, D. E. Kanouse, S. Bernstein.

**OBJECTIVE:** Our purpose was to evaluate the agreement between the documentation of symptoms leading to hysterectomy and the assessment of those symptoms by the patient. **STUDY DESIGN:** A retrospective study was performed of 497 women in southern California who had hysterectomies. Sensitivity, specificity, and kappa statistics were calculated for the medical records and were compared with patient interviews for the presence and severity of symptoms. **RESULTS:** The medical record was 93% sensitive and 61% specific for identifying bleeding and 79% sensitive and 55% specific for identifying pain. Overall agreement between physician records and patient interviews was moderate for bleeding (kappa, 0.55–0.58), fair for pain (kappa, 0.29–0.34), and poor for impairment as a result of bleeding or pain (kappa, 0.0–0.14). **CONCLUSIONS:** Physician overestimation of symptoms could lead to overuse of hysterectomy, whereas underestimation could result in underuse. Our results suggest that both underestimation and overestimation occur for patients with abnormal bleeding, pain, or both. If physicians accurately assess symptoms but fail to document them, examinations of appropriateness will be faulty unless patients are interviewed. Published in *American Journal of Obstetrics and Gynecology*, v. 185, no. 1, Jul. 2001, p. 97–102.

**LRP-200108-02** Psychiatric Disorders and Drug Use Among Human Immunodeficiency Virus-Infected Adults in the United States. E. G. Bing, M. A. Burnam, D. Longshore, J. A. Fleishman, C. D. Sherbourne, A. S. London, Turner Barbara J, F. Eggan, R. Beckman, B. Vitiello, S. C. Morton, M. Orlando, S. A. Bozzette, L. Barron-Ortiz, M. F. Shapiro.

**Background.** There have been no previous nationally representative estimates of the prevalence of mental disorders and drug use among adults receiving care for human immunodeficiency virus (HIV) disease in the United States. It is also not known which clinical and sociodemographic factors are associated with these disorders. **Subjects and Methods.** The authors enrolled a nationally representative probability sample of 2864 adults receiving care for HIV in the United States in 1996. Participants were administered a brief structured psychiatric instrument that screened for psychiatric disorders (major depression, dysthymia, generalized anxiety disorders, and panic attacks) and drug use during the previous 12 months. Sociodemographic and clinical

factors associated with screening positive for any psychiatric disorder and drug dependence were examined in multivariate logistic regression analyses. Results. Nearly half of the sample screened positive for a psychiatric disorder, nearly 40% reported using an illicit drug other than marijuana, and more than 12% screened positive for drug dependence during the previous 12 months. Factors independently associated with screening positive for a psychiatric disorder included number of HIV-related symptoms, illicit drug use, drug dependence, heavy alcohol use, and being unemployed or disabled. Factors independently associated with screening positive for drug dependence included having many HIV-related symptoms, being younger, being heterosexual, having frequent heavy alcohol use, and screening positive for a psychiatric disorder. **Conclusions.** Many people infected with HIV may also have psychiatric and/or drug dependence disorders. Clinicians may need to actively identify those at risk and work with policymakers to ensure the availability of appropriate care for these treatable disorders. Published in *Archives of General Psychiatry*, v. 58, Aug. 2001, p. 721–728.

**LRP-200108-03** Evidence-Based Dentistry and Health Services Research: Is One Possible Without the Other? I. D. Coulter.

Barriers have been identified in the literature to the implementation of evidence-based practice in dentistry. A major concern is the lack of rigorous evidence for clinical practices. Little attention has been given to the lack of rigorous health services research. Evidence-based practice is more about effectiveness than efficacy and will influence the type of research that characterizes health services research (HSR) because it involves levels of data below that of the random controlled trials, involves questions about the appropriateness of care, and involves examining the structure, process, and outcomes of care. The need for HSR can be seen by examining the appropriateness of dental care and health-related quality of life outcomes. The conclusion to be drawn is that evidence-based dentistry needs HSR if it is to fulfill the promise currently held for it in the profession. Published in *Journal of Dental Education*, v. 65, no. 8, Aug. 2001, p. 714–724.

**LRP-200108-07** Life After Radical Prostatectomy: A Longitudinal Study. M. S. Litwin, G. Y. Melmed, T. Nakazon.

**PURPOSE:** We investigate the longitudinal recovery of quality of life after radical prostatectomy in men with localized prostate cancer. **MATERIALS AND METHODS:** We assessed the self-reported health related quality of life in 247 men undergoing radical prostatectomy for prostate cancer. Patients were assessed at baseline before surgery and postoperatively every 3

months for 1 year and then every 6 months for up to 48 months (median 30). We measured general and prostate specific health related quality of life with the RAND 36-Item Health Survey 1.0 SF-36 and University of California, Los Angeles Prostate Cancer Index. The Cox proportional hazards regression model was used to determine whether some patients were more likely than others to have a successful return to baseline functioning after treatment. **RESULTS:** In the SF-36 60% of patients reached baseline in all domains by 3 months. By 12 months, greater than 90% of patients reached baseline in all domains. Mean recovery time for these domains was about 4(1/2) months. The recovery of urinary function to baseline was 21% at 3, 56% at 12 and 63% at 30 months, respectively. About 80% of patients recovered to baseline urinary bother. In the urinary domains patients who recovered did so at an average of 7 to 8 months, and there was little additional recovery after 18 months. By 1 year postoperatively, approximately a third of patients reached baseline sexual function and about half recovered to baseline sexual bother. At 2 years postoperatively, sexual function and bother returned to baseline in 40% and 60% of patients, respectively. Mean recovery time was about 11 months for sexual function and about 9 months for sexual bother. There was little additional recovery in the sexual domains after 18 to 24 months. In the bowel domains more than two thirds of patients returned to baseline by 3 months, and greater than 90% recovered by 12 months, with a mean recovery of 4.8 months. Unmarried men were more likely than those married to regain baseline sexual function ( $p = 0.03$ ) and urinary function ( $p = 0.07$ ). Patients who were 65 years and older were more likely than those younger to return to baseline sexual bother ( $p = 0.03$ ). There were trends that showed patients with higher incomes as well as those who were white were more likely to recover baseline scores for urinary function and the physical component summary. Another trend suggested that men with a higher education were less likely to regain urinary function ( $p = 0.08$ ). **CONCLUSIONS:** Most quality of life recovery occurs early after radical prostatectomy, except in several domains, including urinary and sexual, which continue to improve even beyond 2 years postoperatively. Patients should be encouraged that recovery may continue for months or years after surgery. Published in *The Journal of Urology*, v. 166, no. 2, Aug. 2001, p. 587–592.

**LRP-200108-08** Evaluating an Integrated Approach to Clinical Quality Improvement: Clinical Guidelines, Quality Measurement, and Supportive System Design. S. Cretin, D. O. Farley, K. J. Dolter, W. Nicholas.

**BACKGROUND:** Implementing clinical practice guidelines to change patient outcomes presents a challenge. Studies of single interventions focused on changing provider behavior demonstrate modest effects,

suggesting that effective guideline implementation requires a multifaceted approach. Traditional biomedical research designs are not well suited to evaluating systems interventions. **OBJECTIVES:** RAND and the Army Medical Department collaborated to develop and evaluate a system for implementing guidelines and documenting their effects on patient care. **RESEARCH DESIGN:** The evaluation design blended quality improvement, case study, and epidemiologic methods. A formative evaluation of implementation process and an outcome evaluation of patient impact were combined. **SUBJECTS:** Guidelines were implemented in 3 successive demonstrations targeting low back pain, asthma, and diabetes. This paper reports on the first wave of 4 facilities implementing a low back pain guideline. **METHODS:** Organizational climate and culture, motivation, leadership commitment, and resources were assessed. Selected indicators of processes and outcomes of care were compared before, during, and after guideline implementation at the demonstration facilities and at comparison facilities. Logistic regression analysis was used to test for guideline effects on patient care. **RESULTS:** Process evaluation documented varied approaches to quality improvement across sites. Outcome evaluation revealed a significant downward trend in the percentage of acute low back pain patients referred to physical therapy or chiropractic care (10.7% to 7.2%) at demonstration sites and no such trend at control sites. **CONCLUSIONS:** Preliminary results suggest the power of this design to stimulate improvements in guideline implementation while retaining the power to evaluate rigorously effects on patient care. Published in *Medical Care*, v. 39, no. 8, suppl., 2, Aug. 2001, p. II-70-II-82.

**LRP-200108-09** Screening for Cervical Cancer in HIV-Infected Women Receiving Care in the United States. M. D. Stein, W. E. Cunningham, T. Nakazono, B. J. Turner, R. Andersen, S. A. Bozzette, M. F. Shapiro.

**OBJECTIVE:** The authors examined the sociodemographic, clinical and provider factors associated with screening for cervical cancer among HIV-infected women. **METHODS:** They studied a national sample representing 43,490 women receiving treatment of HIV infection who completed first follow-up surveys of the HIV Cost and Service Utilization Study (HCSUS). All women were asked, "In the past 12 months, have you had a Pap test?" Women reporting an abnormal Pap test result were asked whether they had been told antibiotics could cure abnormal cells, and whether they were scheduled for another Pap test or for a colposcopy within 3 months. **RESULTS:** Of the population represented, 81% had had a Pap test in the past 12 months. Women who reported having a gynecologist and primary care physician at the same clinical site were almost twice as likely (odds ratio, 1.9; 95% confidence interval, 1.3–3.0) as other women to report Pap testing. Among women who reported abnormal

Pap test results and were not told antibiotics could cure abnormal cells, 95% were scheduled for a repeat Pap test or colposcopy, but 15% of the women had not received their repeat Pap test or colposcopy. **CONCLUSION:** Although Pap test rates and appropriate referral for abnormal findings were high among HIV-tested women, many women with initially abnormal Pap test results did not actually receive follow-up Pap testing or colposcopy. Providing gynecologic care at the same site as primary HIV care would likely improve delivery of needed gynecologic care for women. Published in *Journal of Acquired Immune Deficiency Syndrome*, v. 27, no. 5, Aug. 15, 2001, p. 463-466.

**LRP-200108-11** Validation of the Brief Instrumental Functioning Scale in a Homeless Population. J. G. Sullivan, L. Dumenci, M. A. Burnam, P. Koegel.

This report describes the psychometric properties of the six-item Brief Instrumental Functioning Scale (BIFS), a self-report questionnaire for measuring instrumental functioning in community populations, and the results of a study to validate the scale among homeless persons. The participants in the study were 1,509 homeless persons, of whom 1,077, or 71 percent, were seriously mentally ill, substance dependent, or both. Confirmatory factor analysis provided evidence for the unidimensionality of the items in the scale. The BIFS had high internal consistency, respectable stability, and reasonable convergent validity. The BIFS is useful for community populations when self-report data on functioning are required. Additional research is needed to develop and validate comparable scales for assessing other domains of functioning. Published in *Psychiatric Services*, v. 52, no. 8, Aug. 2001, p. 1097-1099.

**LRP-200109-03** Can Quality Improvement Programs for Depression in Primary Care Address Patient Preferences for Treatment? M. Dwight-Johnson, J. Uneutzer, C. D. Sherbourne, L. Tang, K. B. Wells, RAND Health Program.

**BACKGROUND:** Depression is common in primary care, but rates of adequate care are low. Little is known about the role of patient treatment preferences in encouraging entry into care. **OBJECTIVES:** To examine whether a primary care based depression quality improvement (QI) intervention designed to accommodate patient and provider treatment choice increases the likelihood that patients enter depression treatment and receive preferred treatment. **METHODS:** In 46 primary care clinics, patients with current depressive symptoms and either lifetime or current depressive disorder were identified through screening. Treatment preferences, patient characteristics, and use of depression treatments were assessed at baseline and 6 months by patient self-report. Matched clinics were randomized to usual care (UC) or 1

of 2 QI interventions. Data were analyzed using logistic regression models. **RESULTS:** For patients not in care at baseline, the QI interventions increased rates of entry into depression treatment compared with usual care (adjusted percentage: 50.0% +/- 5.3 and 33.0% +/- 4.9 for interventions vs. 15.9% +/- 3.6 for usual care;  $F = 12.973$ ,  $P < 0.0001$ ). Patients in intervention clinics were more likely to get treatments they preferred compared with those in usual care (adjusted percentage: 54.2% +/- 3.3 and 50.7% +/- 3.1 for interventions vs. 40.5% +/- 3.1 for usual care;  $F = 6.034$ ,  $P < 0.003$ ); however, in all clinics less than half of patients preferring counseling reported receiving it. **CONCLUSIONS:** QI interventions that support patient choice can improve the likelihood of patients receiving preferred treatments. Patient treatment preference appears to be related to likelihood of entering depression treatment, and patients preferring counseling may require additional interventions to enhance entry into treatment. Published in *Medical Care*, v. 39, no. 9, Sept. 2001, p. 934-944.

**LRP-200109-05** Changes in Health-Promoting Behavior Following Diagnosis with HIV: Prevalence and Correlates in a National Probability Sample. R. L. Collins, D. E. Kanouse, A. L. Gifford, J. W. Senterfitt, M. A. Schuster, D. McCaffrey, N. S. Wenger.

Diet, exercise, smoking, and substance use patterns affect the course of illness and quality of life for people with HIV. In interviews with a national probability sample of 2,864 persons receiving HIV care, it was found that most had made health-promoting changes in one or more of these behaviors since diagnosis. Many reported increased physical activity (43%) and improved diet (59%). Forty-nine percent of cigarette smokers quit or cut down; 80% of substance users did so. Desire for involvement in one's HIV care and information seeking-positive coping were the most consistent correlates of change. Other correlates varied by health practice but included health status, emotional well-being, demographics, and attitudes toward other aspects of HIV care. Most people with HIV improve their health behavior following diagnosis, but more might be helped to do so by targeting these behaviors in future interventions. Published in *Health Psychology*, v. 20, no. 5, Sept. 2001, p. 351-360.

**LRP-200109-06** Effect of Insurance on Mortality in an HIV-Positive Population in Care. D. P. Goldman, J. Bhattacharya, D. F. McCaffrey, N. Duan, A. A. Leibowitz, G. F. Joyce, S. C. Morton.

As policymakers consider expanding insurance coverage for individuals infected with human immunodeficiency virus (HIV), it is useful to ask if insurance has any affect on health outcomes and, if so, whether its magnitude has changed with recent efficacious but expensive treatments. By using data from a nationally representative cohort of

HIV-infected (HIV+) persons receiving regular medical care, we estimate the impact of insurance on mortality in this population. A naive single-equation model confirms the perverse result found by others in the literature—that insurance increases the probability of death for HIV+ patients. We attribute this finding to a correlation between unobserved health status and insurance status in the mortality equation for two reasons. First, the eligibility rules for Medicaid and Medicare require HIV+ patients to demonstrate a disability, almost always defined as advanced disease, to qualify. Second, if unobserved health status is the cause of the positive correlation, then including measures of HIV+ disease as controls should mitigate the effect. Including measures of immune function (CD4 lymphocyte counts) reduces the effect size by approximately 50%, although it does not change sign. To deal with this correlation, we develop a two-equation parametric model of both insurance and mortality. The effect of insurance on mortality is identified through the judicious use of state policy variables as instruments (variables related to insurance status but not mortality, except through insurance). The results from this model indicate that insurance does have a beneficial effect on outcomes, lowering the probability of 6-month mortality by 71 % at baseline and 85% at follow-up. The larger effect at follow-up can be attributed to the recent introduction of effective therapies for HIV infection, which have magnified the returns to insurance for HIV+ patients (as measured by mortality rates). Published in *Journal of the American Statistical Association*, v. 96, no. 455, Sept. 2001, p. 883–894.

**LRP-200109-07** Patients with Eventually Fatal Chronic Illness: Their Importance Within a National Research Agenda on Improving Patient Safety and Reducing Medical Errors. S. S. Myers, J. Lynn.

In September 2000, the Quality Interagency Coordination (QuIC) Task Force invited the RAND Center to Improve Care of the Dying and Americans for Better Care of the Dying to testify at its National Summit on Medical Errors and Patient Safety Research. In their testimony, the organizations urged the QuIC to consider the special vulnerability and needs of individuals at the end of life in crafting their research agenda. Patients at the end of life are particularly vulnerable to medical errors and other lapses in patient safety for three reasons: (1) substantially increased exposure to medical errors; (2) more serious effects from errors because they cannot protect themselves from risks and have less reserve with which to overcome the effects; and (3) pervasive patterns of care that run counter to well-substantiated evidence-based practices. A national research agenda on preventing medical errors and increasing patient safety must include a focus on how to improve shortcomings affecting these vulnerable patients. The QuIC's preliminary research agenda, released in

October 2000, included patients coming to the end of life. The Agency for Healthcare Research and Quality, the lead federal agency for researching patient safety and medical errors, released between November 2000 and April 2001 six Requests for Applications for research into medical errors. Published in *Journal of Palliative Medicine*, v. 4, no. 3, Fall 2001, p. 325–332.

**LRP-200109-08** Expectations Regarding Aging Among Older Adults and Physicians Who Care for Older Adults. C. A. Sarkisian, R. D. Hays, S. H. Berry, C. M. Mangione.

**BACKGROUND:** Understanding older adults' expectations regarding aging is important for both clinicians and policy-makers. **OBJECTIVES:** 1) To identify the content for a survey to measure expectations regarding aging; 2) to qualitatively compare older adults' and physicians' expectations regarding aging. **SETTING:** Three senior centers and one university-based internal medicine faculty practice. **PARTICIPANTS:** Forty-nine adults (mean age 78 years); 11 primary care clinicians (mean age 37 years). **MEASUREMENTS:** A facilitator conducted five focus groups of older adults and two of physicians using a standardized script designed to elicit expectations regarding aging. Qualitative analysis by two independent reviewers identified domains of expectations, with a 3rd reviewer used to resolve discrepancies. A corresponding coding scheme was applied to each line of the transcripts. Content and frequency of expectations regarding aging and beliefs regarding care seeking were examined and compared. **RESULTS:** Content analysis identified 26 domains of expectations regarding aging. Each of the seven most frequently mentioned domains of expectations was mentioned by at least 50% of participants. Of 760 unique statements coded, the most frequently described domains in both the older adult and physician groups were physical function, cognitive function, social function, pain, and sexual function. Older adults differed from physicians by describing five mental-health related domains: anxiety, emotional-well-being, happiness, sleep, and length of life/death. **CONCLUSIONS:** Using focus groups of older adults and physicians, we identified consistent content for a closed-ended patient-centered survey to measure expectations regarding aging. Further study should determine whether physicians address mental health aspects of aging valued by older persons. Published in *Medical Care*, v. 39, no. 9, Sept. 2001, p. 1025–1036.

**LRP-200109-09** Racial Differences in Cardiac Revascularization Rates: Does "Overuse" Explain Higher Rates Among White Patients? E. C. Schneider, L. L. Leape, J. S. Weissman, R. N. Piana, C. Gatsonis, A. M. Epstein.

**BACKGROUND:** Coronary artery bypass graft (CABG) surgery and percutaneous transluminal coronary angioplasty (PTCA) are well-established treatments for symptomatic coronary artery disease. Previous studies have documented racial differences in rates of use of these cardiac revascularization procedures. Other studies suggest that these procedures are overused: that is, they are done for patients with clinically inappropriate indications. **OBJECTIVE:** To test the hypothesis that the higher rate of cardiac revascularization among white patients is associated with a higher prevalence of overuse (revascularization for clinically inappropriate indications) among white patients than among African-American patients. **DESIGN:** Observational cohort study using Medicare claims and medical record review. **SETTING:** 173 hospitals in five U.S. states. **PARTICIPANTS:** A stratified, weighted, random sample of 3960 Medicare beneficiaries who underwent coronary angiography during 1991 and 1992; 1692 of these patients underwent 1711 revascularization procedures within 90 days. **MEASUREMENTS:** The proportion of CABG and PTCA procedures rated appropriate, uncertain, and inappropriate according to RAND criteria, and the multivariate odds of undergoing inappropriate revascularization among African-American patients and white patients. **RESULTS:** After angiography, rates of PTCA (23% vs. 19%) and CABG surgery (29% vs. 17%) were significantly higher among white patients than among African-American patients. The respective rates of inappropriate PTCA and CABG surgery were 14% and 10%. Among the study states, rates of inappropriate use ranged from 4% to 24% for PTCA and 0% to 14% for CABG surgery. White patients were more likely than African-American patients to receive inappropriate PTCA (15% vs. 9%; difference, 6 percentage points 95% CI, -0.4 to 12.7 percentage points), and difference by race was statistically significant among men (20% vs. 8%; difference, 12 percentage points CI, 1.2 to 21.7 percentage points). Rates of inappropriate CABG surgery did not differ by race (10% in both groups). **CONCLUSIONS:** Among a large and diverse sample of Medicare beneficiaries in five U.S. states, overuse of PTCA was greater among white men than among other groups, but this difference did not fully account for racial disparities in revascularization. Overuse of cardiac revascularization varied significantly by geographic region. Published in *Annals of Internal Medicine*, v. 135, no. 5, Sept. 4, 2001, p.328–337.

**LRP-200109-10** Validity of the Agency for Healthcare Research and Quality Clinical Practice Guidelines: How Quickly Do Guidelines Become Outdated? P. G. Shekelle, E. Ortiz, S. Rhodes, S. C. Morton, M. P. Eccles, J. M. Grimshaw, S. H. Woolf.

Practice guidelines need to be up-to-date to be useful to clinicians. No published methods are available for

assessing whether existing practice guidelines are still valid, nor does any empirical information exist regarding how often such assessments need to be made. **OBJECTIVES:** To assess the current validity of 17 clinical practice guidelines published by the US Agency for Healthcare Research and Quality (AHRQ) that are still in circulation, and to use this information to estimate how quickly guidelines become obsolete. **DESIGN, SETTING, AND PARTICIPANTS:** We developed criteria for defining when a guideline needs updating, mailed surveys to members of the original AHRQ guideline panels (n = 170; response rate, 71%), and searched the literature for evidence through March 2000 (n = 6994 titles yielding 173 articles plus 159 new guidelines on the same topics). **MAIN OUTCOME MEASURES:** Identification of new evidence calling for a major, minor, or no update of the 17 guidelines; survival analysis of the rate at which guidelines became outdated. **RESULTS:** For 7 guidelines, new evidence and expert judgment indicated that a major update is required; 6 were found to be in need of a minor update; 3 were judged as still valid; and for 1 guideline, we could reach no conclusion. Survival analysis indicated that about half the guidelines were outdated in 5.8 years (95% confidence interval CI 5.0–6.6 years). The point at which no more than 90% of the guidelines were still valid was 3.6 years (95% CI, 2.6–4.6 years). **CONCLUSIONS:** More than three quarters of the AHRQ guidelines need updating. As a general rule, guidelines should be reassessed for validity every 3 years. Published in *Journal of the American Medical Association*, v. 286, no. 12, Sept. 2001, p. 1461-1467.

**LRP-200109-11** Cost-Effectiveness of Practice-Initiated Quality Improvement for Depression: Results of a Randomized Controlled Trial. M. Schoenbaum, J. Unutzer, C. D. Sherbourne, N. Duan, L. V. Rubenstein, J. Miranda, L. S. Meredith, M. Carney, K. B. Wells.

**Context:** Depression is a leading cause of disability worldwide, but treatment rates in primary care are low. **Objective:** To determine the cost-effectiveness from a societal perspective of 2 quality improvement (QI) interventions to improve treatment of depression in primary care and their effects on patient employment. **Design:** Group-level randomized controlled trial conducted June 1996 to July 1999. **Setting:** Forty-six primary care clinics in 6 community-based managed care organizations. **Participants:** One hundred eighty-one primary care clinicians and 1356 patients with positive screening results for current depression. **Interventions:** Matched practices were randomly assigned to provide usual care (n = 443 patients) or to 1 of 2 QI interventions offering training to practice leaders and nurses, enhanced educational and assessment resources, and either nurses for medication follow-up (QI-meds; n = 424 patients) or trained local psychotherapists (QI-therapy; n = 489).

Practices could flexibly implement the interventions, which did not assign type of treatment. Main Outcome Measures: Total health care costs, costs per quality-adjusted life-year (QALY), days with depression burden, and employment over 24 months, compared between usual care and the 2 interventions. Results: Relative to usual care, average health care costs increased \$419 (11%) in QI-meds ( $P = .35$ ) and \$485 (13%) in QI-therapy ( $P = .28$ ); estimated costs per QALY gained were between \$15 331 and \$36 467 for QI-meds and \$9478 and \$21 478 for QI-therapy; and patients had 25 ( $P = .19$ ) and 47 ( $P = .01$ ) fewer days with depression burden and were employed 17.9 ( $P = .07$ ) and 20.9 ( $P = .03$ ) more days during the study period. Conclusions: Societal cost-effectiveness of practice-initiated QI efforts for depression is comparable with that of accepted medical interventions. The intervention effects on employment may be of particular interest to employers and other stakeholders. Published in *Journal of the American Medical Association*, v. 286, no. 11, Sept. 19, 2001, p. 1325–1330.

**LRP-200109-12** What Factors Influence Physicians' Decisions to Switch from Intravenous to Oral Antibiotics for Community-Acquired Pneumonia? E. A. Halm, G. E. Switzer, B. S. Mittman, M. B. Walsh, Chung-C. H. Chang, M. J. Fine.

**OBJECTIVE:** One of the major factors influencing length of stay for patients with community-acquired pneumonia is the timing of conversion from intravenous to oral antibiotics. The authors measured physician attitudes and beliefs about the antibiotic switch decision and assessed physician characteristics associated with practice beliefs. **DESIGN:** Written survey assessing attitudes about the antibiotic conversion decision. **SETTING:** Seven teaching and non-teaching hospitals in Pittsburgh, Pa. **PARTICIPANTS:** Three hundred forty-five generalist and specialist attending physicians who manage pneumonia in 7 hospitals. **MEASUREMENTS AND RESULTS:** Factors rated as "very important" to the antibiotic conversion decision were: absence of suppurative infection (93%), ability to maintain oral intake (79%), respiratory rate at baseline (64%), no positive blood cultures (63%), normal temperature (62%), oxygenation at baseline (55%), and mental status at baseline (50%). The median thresholds at which physicians believed a typical patient could be converted to oral therapy were: temperature  $\leq 100$  degrees F (37.8 degrees C), respiratory rate  $\leq 20$  breaths/minute, heart rate  $\leq 100$  beats/minute, systolic blood pressure  $\geq 100$  mm Hg, and room air oxygen saturation  $\geq 90\%$ . Fifty-eight percent of physicians felt that "patients should be afebrile for 24 hours before conversion to oral antibiotics," and 19% said, "patients should receive a standard duration of intravenous antibiotics." In univariate analyses, pulmonary and infectious diseases physicians were the most predisposed

towards early conversion to oral antibiotics, and other medical specialists were the least predisposed, with generalists being intermediate ( $P < .019$ ). In multivariate analyses, practice beliefs were associated with age, inpatient care activities, attitudes about guidelines, and agreeableness on a personality inventory scale. **CONCLUSIONS:** Physicians believed that patients could be switched to oral antibiotics once vital signs and mental status had stabilized and oral intake was possible. However, there was considerable variation in several antibiotic practice beliefs. Guidelines and pathways to streamline antibiotic therapy should include educational strategies to address some of these differences in attitudes. Published in *Journal of General Internal Medicine*, v. 16, no. 9, Sept. 2001, p. 599–605.

**LRP-200109-13** The Quality Improvement for Depression Collaboration General Analytic Strategies for a Coordinated Study of Quality Improvement in Depression Care. K. M. Rost, N. Duan, L. V. Rubenstein, D. E. Ford, C. D. Sherbourne, L. S. Meredith, K. B. Wells.

It is difficult to evaluate the promise of primary care quality-improvement interventions for depression because published studies have evaluated diverse interventions by using different research designs in dissimilar populations. Preplanned meta-analysis provides an alternative to derive more precise and generalizable estimates of intervention effects; however, this approach requires the resolution of analytic challenges resulting from design differences that threaten internal and external validity. This paper describes the four-project Quality Improvement for Depression (QID) collaboration specifically designed for preplanned meta-analysis of intervention effects on outcomes. This paper summarizes the interventions the four projects tested, characterizes commonalities and heterogeneity in the research designs use to evaluate these interventions, and discusses the implications of this heterogeneity for preplanned meta-analysis. Published in *General Hospital Psychiatry*, v. 23, no. 5, Sept.-Oct. 2001, p. 239–253.

**LRP-200109-14** Utilization of Birth Control Services Among Homeless Women. S. L. Wenzel, B. Leake, R. Andersen, L. Gelberg.

Although homeless women appear to be at notable risk of unintended pregnancy, insufficient attention has been paid to understanding their access to birth control services and the characteristics of homeless women who want birth control services. To address these research gaps, the authors analyzed data from a probability sample of 974 homeless women who were interviewed in shelters and meal programs in Los Angeles County. Multivariate logistic regression analysis revealed that among those women who wanted birth control services during the past year, using these services was associated with fewer

perceived barriers to health care, having a regular source of care, consistent use of contraception, and lower odds of alcohol dependence. Availability and cost barriers to birth control services must be reduced, and effective service linkages should be developed among providers of birth control services, substance abuse treatment and primary care. Published in *American Behavioral Scientist*, v.45, no. 1 Sept. 2001, p. 14–34.

**LRP-200109-15** Effects of Drug Abuse and Mental Disorders on Use and Type of Antiretroviral Therapy in HIV-Infected Persons. B. J. Turner, J. A. Fleishman, N. Wenger, A. S. London, M. A. Burnam, M. F. Shapiro, E. G. Bing, M. D. Stein, D. Longshore, S. A. Bozzette.

**OBJECTIVE:** To distinguish the effects of drug abuse, mental disorders, and problem drinking on antiretroviral therapy (ART) and highly active ART (HAART) use. **DESIGN:** Prospective population-based probability sample of 2,267 (representing 213,308) HIV-infected persons in care in the United States in early 1996. **MEASUREMENTS:** Self-reported ART from first (January 1997–July 1997) to second (August 1997–January 1998) follow-up interviews. Drug abuse/dependence, severity of abuse, alcohol use, and probable mental disorders assessed in the first follow-up interview. Adjusted odds ratios (AORs) and 95% confidence intervals (CIs) estimated from weighted models for 1) receipt of any ART, and 2) receipt of HAART among those on ART. **RESULTS:** Of our study population, ART was reported by 90% and HAART by 61%. Over one third had a probable mental disorder and nearly half had abused any drugs, but drug dependence (9%) or severe abuse (10%) was infrequent. Any ART was less likely for persons with dysthymia (AOR, 0.74; CI, 0.58 to 0.95) but only before adjustment for drug abuse. After full adjustment with mental health and drug abuse variables, any ART was less likely for drug dependence (AOR, 0.58; CI, 0.34 to 0.97), severe drug abuse (AOR, 0.52; CI, 0.32 to 0.87), and HIV risk from injection drug use (AOR, 0.55; CI, 0.39 to 0.79). Among drug users on ART, only mental health treatment was associated with HAART (AOR, 1.57; CI, 1.11 to 2.08). **CONCLUSIONS:** Drug abuse-related factors were greater barriers to ART use in this national sample than mental disorders but once on ART, these factors were unrelated to type of therapy. Published in *Journal of General Internal Medicine*, v. 16, no. 9, Sept. 2001, p. 625–633.

**LRP-200109-16** Weighting for Period Perspective in Samples of the Homeless. G. C. Sumner, R. Andersen, S. L. Wenzel, L. Gelberg.

For some sample-based studies of the homeless, it may be relevant to adopt a period perspective, in which analyses focus on the mix of persons who experience homelessness at least once during some period of time, not just the mix

of persons at a point in time. Period perspective presumably can be enhanced by weights that account for the intermittent nature of homelessness, but such weighting invites implementation problems related to calculation, specifying the weighting model, measurement, and especially weight disparity. Some of these problems can be mitigated by a sample design that assures independence between selection and individual respondent behavior, but remaining difficulties, particularly weight variability, raise questions about how weighting should be used in this context. Published in *American Behavioral Scientist*, v. 45, no. 1, Sept. 2001, p. 80–104.

**LRP-200110-02** Sensitivity and Specificity of the RAND/UCLA Appropriateness Method to Identify the Overuse of Coronary Revascularization and Hysterectomy. P. G. Shekelle, R. E. Park, J. P. Kahan, L. L. Leape, C. J. Kamberg, S. Bernstein.

There is no empirical evidence on the sensitivity and specificity of methods to identify the possible overuse and underuse of medical procedures. To estimate the sensitivity and specificity of the RAND/UCLA Appropriateness Method. Parallel three-way replication of the RAND/UCLA Appropriateness Method for each of two procedures, coronary revascularization and hysterectomy. Maximum likelihood estimates of the sensitivity and specificity of the method for each procedure. These values were then used to re-calculate past estimates of overuse and underuse, correcting for the error rate in the appropriateness method. The sensitivity of detecting overuse of coronary revascularization was 68% (95% confidence interval 60–76%) and the specificity was 99% (98–100%). The corresponding values for hysterectomy were 89% (85–94%) and 86% (83–89%). The sensitivity and specificity of detecting the underuse of coronary revascularization were 94% (92–95%) and 97% (96–98%), respectively. Past applications of the appropriateness method have overestimated the prevalence of the overuse of hysterectomy, underestimated the prevalence of the overuse of the coronary revascularization, and provided true estimates of the underuse of revascularization. The sensitivity and specificity of the RAND/UCLA Appropriateness Method vary according to the procedure assessed and appear to estimate the underuse of procedures more accurately than their overuse. Published in *Journal of Clinical Epidemiology*, v. 54, no. 10, Oct. 2001, p. 1004–1010.

**LRP-200111-01** Improvement in Emotional Well-Being and Relationships of Users of Sildenafil. N. M. Paige, R. D. Hays, M. S. Litwin, J. Rajfer, M. F. Shapiro.

**Purpose:** We estimated the association of sildenafil use with erectile function, relationships with sexual partner, functional status and emotional well-being in men with erectile dysfunction. **Materials and Methods:** Letters were

mailed to eligible patients at a university hospital urology and internal medicine clinic, and university affiliated community primary care clinics by the primary care provider or urologist inviting them to participate in the study. Of the eligible sample 124 men (53%) completed and returned a survey, including 85 who reported current sildenafil use. Change scores in these patients were calculated using the International Index of Erectile Function, marital interaction scale from the Cancer Rehabilitation Evaluation System Short Form, 5-item emotional well-being scale of the RAND 36-Item Health Survey and 12-Item Short Form Health Survey. Results: Sildenafil users reported an 88% increase in erectile function scores, 60% increase in overall sexual satisfaction and 36% increase in intercourse satisfaction related to the use of sildenafil ( $p < 0.001$ ). Of the respondents 38% indicated that using sildenafil had definitely improved quality of life. Likewise 29% of respondents indicated that using sildenafil had definitely improved the relationship with their partner. With sildenafil there was a statistically significant improvement in the scores of erectile and sexual function ( $p < 0.001$ ), sexual partner relationship ( $p = 0.007$ ) and emotional well-being ( $p < 0.001$ ). In a multivariate model improved erectile function and sexual partner relationship were each significantly associated with improved emotional well-being ( $R^2 = 0.20$ ,  $p < 0.001$ ). Conclusions: Sildenafil users reported significant improvements in erectile and sexual function that were associated with positive changes in emotional well-being and the sexual partner relationships with their sexual partner. Published in *The Journal of Urology*, v. 166, no. 5, Nov. 2001, p. 1774–1778.

**LRP-200111-02** Cigarette Taxes and Smoking During Pregnancy. J. S. Ringel, W. N. Evans.

**OBJECTIVES:** This study sought to estimate how changes in state cigarette excise taxes affect the smoking behavior of pregnant women. **METHODS:** Detailed information about mothers and their pregnancy was used to examine the impact of taxes on the propensity of pregnant women to smoke. The 1989 to 1995 Natalty Detail Files were used in conducting analyses to assess the impact of taxes on smoking among different subpopulations. **RESULTS:** Higher cigarette excise taxes reduced smoking rates among pregnant women. A tax hike of \$0.55 per pack would reduce maternal smoking by about 22%. Overall, a 10% increase in price would reduce smoking rates by 7%. Estimates for subpopulations suggested that nearly all would be very responsive to tax changes, including the subpopulations with the highest smoking rates. **CONCLUSIONS:** Smoking rates among pregnant women are responsive to tax hikes. Published in *American journal of Public Health*, v. 91, n. 11, Nov. 2001, p. 1851–1856.

**LRP-200111-03** Predictors and Prevention of Nonfatal Overdose Among Street-Recruited Injection Heroin Users in San Francisco Bay Area, 1998-1999. K. H. Seal, A. H. Kral, L. Gee, L. D. Moore, R. N. Bluthenthal, J. Lorvic, B. R. Edlin.

**OBJECTIVES:** This study sought to determine prevalence of and risk factors for nonfatal recent overdose among street-recruited injection heroin users. **METHODS:** From August 1998 through July 1999, 1427 heroin injectors were recruited from 6 inner-city neighborhoods in the San Francisco Bay Area, Calif, and interviewed. Factors hypothesized to be associated with recent overdose were analyzed with logistic regression. **RESULTS:** Of the 1427 participants, 684 (48%) had had an overdose, 466 (33%) had experienced 2 or more overdose events, and 182 (13%) had had a recent overdose. In multiple logistic regression, being younger (adjusted odds ratio *OR* for each year of increasing age = 0.95; 95% confidence interval *CI* = 0.94, 0.97), having been arrested 3 or more times in the past year (adjusted *OR* = 2.50; 95% *CI* = 1.61, 3.87), drinking 4 or more alcoholic drinks per day (adjusted *OR* = 2.05; 95% *CI* = 1.37, 3.05), and having participated in methadone detoxification during the past year (adjusted *OR* = 1.47; 95% *CI* = 1.03, 2.09) were independently associated with recent overdose. Being homeless; identifying as gay, lesbian, bisexual, or transgender; having spent 5 or more years in prison or jail; and having engaged in sex work also were associated with recent overdose. **CONCLUSIONS:** Targeted interventions that decrease risk for overdose are urgently needed. Published in *American Journal of Public Health*, v. 91, n. 11, Nov. 2001, p. 1842–1846.

**LRP-200111-04** Trends in HIV Seroprevalence and Risk Among Gay and Bisexual Men Who Inject Drugs in San Francisco, 1988 to 2000. R. N. Bluthenthal, A. H. Kral, L. Gee, J. Lorvick, L. Moore, K. Seal, B. R. Edlin.

**OBJECTIVES:** To determine trends in HIV infection and risk behaviors among street-recruited self-identified gay and bisexual male injection drug users (IDUs) in San Francisco. **METHODS:** Trends in HIV infection and risk behaviors were calculated for gay/bisexual (  $n = 1594$  interviews) IDUs in 26 semiannual cross sections from 1988 to 2000. **RESULTS:** HIV seroprevalence among gay/bisexual IDUs decreased from the range of 35% to 45% in 1988/1989 to 25% in 1996 and then began to increase, reaching 42% in 2000. In contrast, HIV prevalence among heterosexual male IDUs remained stable during the study period. For gay/bisexual IDUs, injection and sex-related HIV risk behaviors declined modestly throughout the study period. As of the last cross section (July 2000), however, over a third of respondents reported recent syringe sharing or unprotected anal sex. **CONCLUSIONS:** Gay/bisexual men who inject drugs continue to be at elevated risk for HIV, suggesting that

interventions such as amphetamine drug treatment and sexual risk reduction programs targeted at this population are needed. Published in *Journal of Acquired Immune Deficiency Syndrome*, v. 28, no. 3, Nov. 1, 2001, p. 264–269.

**LRP-200111-05** Randomized Testing of Alternative Survey Formats Using Anonymous Volunteers on the World Wide Web. D. S. Bell, C. M. Mangione, C. E. Kahn.

Consenting visitors to a health survey Web site were randomly assigned to a "matrix" presentation or an "expanded" presentation of survey response options. Among 4,208 visitors to the site over 3 months, 1,615 (38 percent) participated by giving consent and completing the survey. During a pre-trial period, when consent was not required, 914 of 1,667 visitors (55 percent) participated (odds ratio 1.9,  $P < 0.0001$ ). Mean response times were 5.07 minutes for the matrix format and 5.22 minutes for the expanded format ( $P = 0.16$ ). Neither health status scores nor alpha reliability coefficients were substantially influenced by the survey format, but health status scores varied with age and gender as expected from U.S. population norms. In conclusion, presenting response options in a matrix format may not substantially speed survey completion. This study demonstrates a method for rapidly evaluating interface design alternatives using anonymous Web volunteers who have provided informed consent. Published in *Journal of the American Medical Informatics Association*, v. 8, no. 6, Nov. 2001, p. 616–620.

**LRP-200111-06** Financing of Care for Fatal Chronic Disease: Opportunities for Medicare Reform. J. Lynn, A. Wilkinson, L. Etheredge.

Published in *Western Journal of Medicine*, v. 175, no. 5, Nov. 2001, p. 299–302.

**LRP-200111-07** A National Survey of Stress Reactions After the September 11, 2001, Terrorist Attacks. M. A. Schuster, B. D. Stein, L. Jaycox, R. L. Collins, G. N. Marshall, M. N. Elliott, A. J. Zhou, D. E. Kanouse, J. L. Morrison, S. H. Berry.

Background. People who are not present at a traumatic event may experience stress reactions. The authors assessed the immediate mental health effects of the terrorist attacks on September 11, 2001. Methods. Using random-digit dialing three to five days after September 11, we interviewed a nationally representative sample of 560 U.S. adults about their reactions to the terrorist attacks and their perceptions of their children's reactions. Results. Forty-four percent of the adults reported one or more substantial symptoms of stress; 90 percent had one or more symptoms to at least some degree. Respondents throughout the country reported stress symptoms. They

coped by talking with others (98 percent), turning to religion (90 percent), participating in group activities (60 percent), and making donations (36 percent). Eighty-four percent of parents reported that they or other adults in the household had talked to their children about the attacks for an hour or more; 34 percent restricted their children's television viewing. Thirty-five percent of children had one or more stress symptoms, and 47 percent were worried about their own safety or the safety of loved ones. Conclusions. After the September 11 terrorist attacks, Americans across the country, including children, had substantial symptoms of stress. Even clinicians who practice in regions that are far from the recent attacks should be prepared to assist people with trauma-related symptoms of stress. Published in *New England Journal of Medicine*, v. 345, no. 20, Nov. 15, 2001, p. 1507–1512.

**LRP-200111-08** Effects of Cost Sharing on Care Seeking and Health Status: Results from the Medical Outcomes Study. M. D. Wong, R. Andersen, C. D. Sherbourne, R. D. Hays, M. F. Shapiro.

OBJECTIVES: This study sought to determine the effect of cost sharing on medical care use for acute symptoms and on health status among chronically ill adults. METHODS: Data from the Medical Outcomes Study were used to compare (1) rates of physician care use for minor and serious symptoms and (2) 6- and 12-month follow-up physical and mental health status among individuals at different levels of cost sharing. RESULTS: In comparison with a no-copay group, the low- and high-copay groups were less likely to have sought care for minor symptoms, but only the high-copay group had a lower rate of seeking care for serious symptoms. Follow-up physical and mental health status scores were similar among the 3 copay groups. CONCLUSIONS: In a chronically ill population, cost sharing reduced the use of care for both minor and serious symptoms. Although no differences in self-reported health status were observed, health plans featuring cost sharing need careful monitoring for potential adverse health effects because of their propensity to reduce use of care that is considered necessary and appropriate. Published in *American Journal of Public Health*, v. 91, no. 11, Nov. 2001, p. 1889–1894

**LRP-200111-09** Access to Inpatient or Residential Substance Abuse Treatment Among Homeless Adults with Alcohol or Other Drug Use Disorders. S. L. Wenzel, M. A. Burnam, P. Koegel, S. C. Morton, A. Miu, K. J. Jinnett, J. G. Sullivan.

The authors conducted a theoretically guided study of access to inpatient or residential treatment among a probability sample of homeless adults with alcohol or drug use disorders in Houston, Texas. METHODS: This study used a cross-sectional, retrospective design with data collected from a multistage random sample of 797

homeless adults age 18 or older who were living in Houston shelters and streets in 1996. Structured, face-to-face interviews produced screening diagnoses for alcohol and drug use disorders, treatment use data, and candidate predictors of treatment use. Logistic and linear regression analyses were performed on the subset of 326 homeless persons with either alcohol or drug use disorder. **RESULTS:** 27.5% of persons with substance use disorder had accessed inpatient or residential treatment during the past year. Controlling for additional need factors such as comorbidity, persons having public health insurance and a history of treatment for substance problems had greater odds of receiving at least one night of treatment. Contrary to expectation, contact with other service sectors was not predictive of treatment access. Schizophrenia and having a partner appeared to hinder access. Greater need for treatment was associated with fewer nights of treatment, suggesting retention difficulties. **CONCLUSIONS:** This study adds to previous findings on access to health care among homeless persons and highlights a pattern of disparities in substance abuse treatment access. Health insurance is important, but enhancing access to care involves more than economic considerations if homeless persons are to receive the treatment they need. Referral relationships across different service sectors may require strengthening. Published in *Medical Care*, v. 39, no. 11, Nov. 2001, p. 1158–1169.

**LRP-200112-01** The Care of HIV-Infected Adults in Rural Areas of the United States. S. E. Cohn, M. L. Berk, S. H. Berry, N. Duan, M. R. Frankel, J. D. Klein, M. M. McKinney, A. Rastegar, S. Smith, M. F. Shapiro, S. A. Bozzette.

**OBJECTIVE:** This study describes the population of HIV-infected adults receiving care in rural areas of the United States and compares HIV care received in rural and urban areas. **METHODS:** Interviews were conducted with a nationally representative sample of 367 HIV-infected adults receiving health care in rural areas and 2806 HIV-infected adults receiving health care in urban areas of the contiguous United States. **RESULTS:** The authors estimate that 4800 HIV-infected persons received medical care in rural areas during the first half of 1996. Patients in rural HIV care were more likely than patients in urban HIV care to receive care from providers seeing few (<10) HIV-infected patients (38% vs. 3%;  $p < .001$ ). Rural care patients were less likely than urban care patients to have taken highly active antiretroviral agents (57% vs. 73%;  $p < .001$ ) or *Pneumocystis carinii* pneumonia prophylactic medication when indicated (60% vs. 75%;  $p = .006$ ). **CONCLUSIONS:** Few American adults received HIV care in rural areas of the United States. Their findings suggest ongoing disparities between urban and rural areas in access to high-quality HIV care. Published in *Journal of*

*Acquired Immune Deficiency Syndrome*, v. 28, no. 4, Dec. 1, 2001, p. 385–392.

**LRP-200112-02** Underuse of Primary *Mycobacterium Avium* Complex and *Pneumocystis Carinii* Prophylaxis in the United States. S. M. Asch, A. L. Gifford, S. A. Bozzette, B. Turner, C. Mathews, K. Kuromiya, W. Cunningham, R. Andersen, M. Shapiro, A. Rastegar, J. A. McCutchan.

**BACKGROUND:** Little is known about the rates of *Mycobacterium avium* complex (MAC) and *Pneumocystis carinii* (PCP) prophylaxis adherence to guidelines and how they have changed after introduction of effective antiretroviral therapy. **OBJECTIVE:** To determine rates of primary prophylaxis for MAC and PCP and to evaluate the influence of sociodemographic characteristics, region, and provider experience. **DESIGN:** National probability sample cohort of HIV patients in care. **SETTING:** One hundred sixty HIV health care providers. **PATIENTS:** A total of 2864 patients interviewed in 1996 to 1997 (68% response) and 2267 follow-up interviews, representing 65% of surviving sampled patients (median follow-up, 15.1 months). **MEASUREMENTS:** Use of prophylactic drugs, most recent CD4 count, sociodemographics, and regional and total HIV patients/providers. **RESULTS:** Of patients eligible for primary MAC prophylaxis (most recent CD4 count  $< 50/\text{mm}^3$ ), 41% at baseline and 40% at follow-up patients were treated. Of patients eligible for primary PCP prophylaxis (i.e., those with CD4 counts  $< 200/\text{mm}^3$ ), 64% and 72% were treated, respectively. MAC prophylaxis at baseline was less likely in African American (adjusted odds ratio *OR* .35; 95% confidence interval *CI* 0.20–0.59), Hispanic (*OR*, 27; 95% *CI*, 0.08–0.94) and less-educated (*OR*, 0.61; 95% *CI*, 0.36–1.0) patients and more likely in U. S. geographic regions in the Pacific West (*OR*, 4.9; 95% *CI*, 1.0–23) and Midwest (*OR*, 6.4; 95% *CI*, 1.2–33) and in practices with more HIV patients. **CONCLUSIONS:** Most eligible patients did not receive MAC prophylaxis; PCP prophylaxis rates were better but still suboptimal. Our results support outreach efforts to African Americans, Hispanics, the less educated, and those in the northeastern United States and in practices with fewer HIV patients. Published in *Journal of Acquired Immune Deficiency Syndromes*, v. 28, no. 4, Dec. 1, 2001, p. 340–344.

**LRP-20010110** The Time Course of Treatment Cost Among Patients with Severe Mental Illness. A. S. Young, K. Kapur, D. Murata.

This issue of *Datapoints* examines the effects of adjusting payments for treatment of the severely mentally ill according to the risk of high future costs. Published in *Psychiatric Services*, v. 52, no. 1 (*Datapoints*), Jan. 2001, p. 21.

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