In March 2000, AHRQ issued a request for proposals soliciting teams of partners and associated collaborators to participate in IDSRN. Teams were to marry research to practice by having researchers embedded in or collaborating with operational managed care plans, hospital-based integrated delivery systems, large multi-specialty groups, or safety net providers. In September 2000, AHRQ made awards to nine such consortia (see Table 1). Five of the nine were led by organizations with a direct connection to insurance or health services delivery systems, some with affiliated outside research partners. The other four teams were based outside of the delivery system in universities or research firms whose primary mission did not involve health care delivery, though they were affiliated with such entities. Teams selected for IDSRN were not awarded funding upon selection but did receive the (exclusive) right to respond to IDSRN requests for task orders – individual contracts awarded for specified projects.

Most IDSRN projects were awarded on a competitive basis using a contract (rather than grant) mechanism. Under the IDSRN contract mechanism, applications were typically due a few weeks after AHRQ released a request for task order. Applications were then reviewed by AHRQ and moved through an expedited award process. This task order award process differs markedly in internal control and speed from the more traditional processes that AHRQ uses to award grants. Being selected for the IDSRN program meant that teams were eligible to compete to propose and carry out specific types of projects. AHRQ engaged in some dialogue with the teams to gather ideas for topics, although the process was not very structured. Projects also were solicited on topics that arose across AHRQ, or more broadly within the U.S. Department of Health and Human Services (HHS) (e.g., interest in bioterrorism or racial/ethnic disparities in health care).

During the period FY 2000–2003 (the period of our analysis), AHRQ awarded 58 separate IDSRN projects totaling $14.2 million, funded both through core AHRQ funds and through more dedicated sources, particularly in the areas of patient safety and bioterrorism. Projects were expected to produce relatively rapid results, with most contracts spanning 12 to 18 months.

IDSRN projects were diverse and spanned almost all of the areas of interest within AHRQ. Most awards were in five broad areas: quality improvement and patient safety; system capacity and emergency preparedness; cost, organization, and socioeconomics; health information technology; and data development. AHRQ solicited proposals for projects that typically had some operational link. Funding, timing, and AHRQ staff interest largely drove the composition of projects included in IDSRN.

Methods

Our evaluation is descriptive in nature. It aims to help program sponsors and participants learn more about how the program and teams worked, with the goal of generating formative feedback that could be used to refine the program. Sponsors viewed such a design as appropriate given the limited knowledge of how to implement research into practice and the practical constraints on a more rigorous assessment. These included timing (the evaluation was not solicited until well after the program began), structure (the program was not designed to yield comparison groups or baseline data which could enhance assessment of impact), and funding (the evaluation was not funded at a level that supported primary data collection outside of interviews with IDSRN participants). These factors obviously constrain the scope and sophistication of the findings but are not surprising given the fact that IDSRN involved a broad-based and fluid initiative in an emerging area.

For this study, we examined the first four years of IDSRN over a 12-month period, starting in October 2003. We reviewed relevant documents, including AHRQ documents about the program overall and documents related to individual projects (e.g., proposals and final reports);

Table 1: IDSRN partners and main collaborators

Led by operationally based partner
• The HMO Research Network, a longstanding network of research affiliates of large integrated and prepaid systems[a]
• Denver Health, a large integrated safety net provider system
• Weill Medical College/New York Presbyterian, a large urban medical system
• Marshfield Clinic, a rural group practice (with Project Hope)
• United Healthcare, a major national health insurer (through their Center for Health Care Policy and Evaluation and a subcontract with RAND)
Led by others
• Abt Associates (with Geisinger Health Systems)
• Emory University's Center for Health Outcomes and Quality (originally based at Aetna, with whom it continued to collaborate)
• Research Triangle International (RTI) (with multiple provider systems)
• University of Minnesota's Division of Health Services Research and Policy (with Blue Cross Blue Shield of Minnesota, the Medical Group Management Association and others)

[a] See Vogt et al. [12] for more information on the HMO Research Network.