Section 2713 of the Patient Protection and Affordable Care Act that President Obama signed into law on March 23 contains lessons for those who believe in evidence-based policy and practice. The passage above tells potential users to ignore a recent evidence-based practice recommendation. This curious legislative language was, of course, the outcome of a public controversy that began with the publication in November 2009 of the Preventive Service Task Force’s updated recommendations on the use of screening mammograms.

For a professional society whose members are engaged in the enterprise of generating evidence that might inform policy, it is worth considering why research can stimulate powerful objections.

The Mammography Screening Recommendations

In November 2009, the U.S. Preventive Services Task Force (USPSTF) published new recommendations about routine breast cancer screening mammography.1 If followed, the new recommendations would reduce substantially the use of the procedure among women ages 40 to 49.2 The 2009 recommendations, which replaced guidance issued in 2002, were based on a detailed review and analysis of the relevant research. They called for the continuation of routine screening mammography among women age 50 and older, but not for younger women who had no specific risk factors. The Task Force explained that “for biennial screening mammography in women aged 40 to 49 years, there is moderate certainty that the net benefit is small”3 and that the harms associated with breast cancer screening outweighed the benefits. These harms include “psychological harms, unnecessary imaging tests, biopsies in women without cancer, and inconvenience due to false-positive screening results.” They also include “harms associated with treatment of cancer that would not have become clinically apparent during a woman’s lifetime (overdiagnosis), as well as the harms of unnecessary earlier treatment of breast cancer that would have become clinically apparent but would not have shortened a woman’s life.”4

The Task Force enjoys a reputation for independence and quality, and some responses to its mammography recommendations were positive. Groups such as Breast Cancer Action, the National Women’s Health Network, the National Breast Cancer Coalition, and Our Bodies Ourselves, embraced the recommendations. The recommendations were touted by some leading health policy researchers as “rational”5 and “objective.”6 Yet, the positive evaluations were overwhelmed by an avalanche of negative reactions from professional associations, patient advocates, and elected officials from both political parties.7 Some of the opposition came from organizations with obvious economic interests, but strong objections also came from advocacy organizations like the American Cancer

Continued on page 4
As the nation forges ahead in today's new era of health reform, the field of health services research is well positioned to support the implementation and evaluation of this historic legislation. As evident in the panels and research presented at this year's Annual Research Meeting, the field possesses the expertise and insight that will be essential for informed decision-making. Our challenge is to continue building and maintaining the infrastructure needed to support the increasing demand for our work.

Reflecting on my 11-year tenure as president and chief executive of this organization and my membership in the Association for Health Services Research (AHSR) and position as leader of the Alpha Center, I can say with certainty that AcademyHealth has never been better poised to meet the needs of our nation's policymakers and practitioners. We have a highly capable and dedicated staff, a vibrant and growing membership, a strong financial position, and a distinguished Board of Directors that understands the challenges of guiding a professional society. With these strengths and capabilities, AcademyHealth has the commensurate skills and substantive experience to continue its well-established leadership role in supporting health and health care improvement. And, while the field embraces new opportunities, I am preparing for a new era of my own: my retirement as your president later this year.

The board and staff are fully prepared for the transition, guided by a strategic plan and governance review developed over the last few years under a transition committee led by Sara Rosenbaum and John Colmers. With their guidance, the board has begun its search for a new chief executive with the skills and experience needed to lead this dynamic organization. Under a new CEO, AcademyHealth's staff will continue their efforts to support the development of the field, facilitate the use of the best available research and information, and assist health policy and practice leaders in addressing major health challenges. Without a doubt, the new executive will value as I do the staff's ability to launch important new projects, expand our offerings to enhance your professional development, and improve membership services and our national conferences.

The new CEO will also benefit from the leadership provided by the Board of Directors of the Coalition for Health Services Research in directing our advocacy for the health services research field. In recent years, the board has spearheaded our efforts to secure significant funding increases to support health services and comparative effectiveness research, the national data systems needed by our researchers and policy analysts, and policies that ensure the timely publication of research.

Of course, none of this is possible without you, our members. Engaged members are the lifeblood of our organization and our field. Working together with the board and staff, you can achieve AcademyHealth's vision of improving health and health care by generating new knowledge and moving knowledge into action. I look forward to joining you on that journey.

W. David Helms, Ph.D.
President and CEO
AcademyHealth
The Latest

Members to Elect Two New Directors for Board: Same Process, New Timing

This year, AcademyHealth will open voting for the Board of Directors member election to coincide with the start of the Annual Research Meeting (ARM). Online voting will open on June 27 and close at 5 p.m. EDT on July 30. AcademyHealth members will receive voting instructions by email in advance of the election, along with information on the candidates. Members attending the ARM will be encouraged to vote at available on-site computers.

This is your opportunity to make your voice heard in selecting AcademyHealth’s leaders. Your vote does matter. Members active on June 1 may vote online for two of the following four candidates:

→ Romana Hasnain-Wynia, Ph.D., director, Center for Healthcare Equity, and associate professor, research organization: Northwestern University, Feinberg School of Medicine
→ Len M. Nichols, Ph.D., director, Center for Health Policy Research and Ethics, George Mason University
→ Eduardo J. Sanchez, M.D., M.P.H., vice president and chief medical officer, Blue Cross and Blue Shield of Texas
→ Kevin A. Schulman, M.D., professor of medicine and business administration, Duke University

Earlier this spring, the Board elected three directors to the 2011 Board. Carmen Hooker Odom, M.R.P., president, Milbank Memorial Fund, and Craig V. Thornton, Ph.D., managing director for health research, Mathematica Policy Research, Inc. were elected to a first term, and Lisa Rubenstein, M.D., professor of medicine and public health, VA Greater Los Angeles and UCLA, will rejoin the board for a second term.

Questions about the election process may be directed to Bonnie Austin, director, at 202.292.6756.

AcademyHealth Prepares to Help States Policymakers Implement Federal Reforms

State Coverage Initiatives (SCI), a national program of the Robert Wood Johnson Foundation administered by AcademyHealth, has had a tremendously busy year. Even before federal health reform was enacted, SCI was preparing to support states in the event that some form of the legislation would pass while also recognizing that many states were working on reforms regardless of whether or not federal reform occurred.

With the knowledge that many states were contemplating creating or already working towards implementing exchanges as a way to improve the individual and small group markets, SCI partnered with the Massachusetts Health Insurance Connector Authority to host a meeting January 21-22, 2010, on health reform in Massachusetts. This meeting focused on the organization and implementation of health insurance exchanges. More than 150 participants representing 41 states and the District of Columbia were in attendance. The meeting addressed the benefits and challenges of implementing an exchange, the operational aspects of running the subsidized Commonwealth Choice programs, the outreach and educational efforts the Connector Authority undertook, and other important topics.

As a result of the meeting, SCI produced an issue brief, “Preparing for Health Reform: The Role of the Health Insurance Exchange.” This report provides policymakers with an overview of the potential role of a health insurance exchange, what a state should do to prepare for the creation of an exchange, state-specific issues that should be considered before establishing an exchange, and the different ways in which an exchange might be structured and operated. Bob Carey, the author of the brief, joined SCI for a webinar to discuss his findings with state officials.

Another recent report, “Implementing State Health Reform: Lessons for Policymakers,” prepared by Navigant Consulting for SCI, draws on the reform implementation experiences of five states: Massachusetts, New Mexico, Tennessee, Vermont, and Wisconsin. The report identifies not only the key questions that policymakers should ask when considering various aspects of health care reform, but also provides a set of related takeaways, particularly about what must happen operationally pre- and post-implementation. The questions and takeaways are relevant to both state and national reform initiatives because state governments are typically charged with implementing reforms and state experiences offer insight into the overall design of reforms.

Understanding these issues is particularly critical now as the enactment of federal reform has enormous implementation implications for states. SCI is currently in the final stages of producing two additional briefs; one focusing on providing an overview of all-payer claims databases for state policymakers and the other looking at the potential for value-based purchasing and consumer engagement by state employee health plan purchasers.

Now that health reform is law, the SCI program hopes to join state officials on the journey of operationalizing health reform and recognizing that a lot of hard work lies ahead for states as they take a major role in implementing the core components of the law. One of our major goals here at SCI is to focus technical assistance on the implementation of exchanges and other insurance market reforms as defined in the final legislation.

For more information, please visit our website at www.academyhealth.org.
Society, Susan G. Komen for the Cure® stated that, “There is enough uncertainty about the age at which mammography should begin and the frequency of screening that we would not want to see a change in policy for screening mammography at this time.” Objections also came from within the medical profession. Former NIH Director Bernadine Healy, M.D., said on Fox News, “I’m saying very powerfully [to] ignore [the recommendations], because unequivocally ... this will increase the number of women dying of breast cancer.”

Some political leaders also responded with strong criticism. Within two weeks of their release, Secretary Sebelius decried the “confusion and worry” the recommendations had stimulated and noted that the Task Force does not “set federal policy and [doesn’t] determine what services are covered by the federal government.” She advised the public, “Keep doing what you have been doing for years; talk to your doctor about your individual history, ask questions, and make the decision that is right for you.” Within a month, the Senate agreed by voice vote to an amendment that effectively required the federal government to ignore the Task Force’s recommendations. In altered form, but not changed substance, the amendment found its way into the health reform legislation.

**Lessons from the Mammography Controversy**

It is not unprecedented for new practice guidelines to generate powerful opposition, as when the very funding of the Agency for Health Care Policy and Research was successfully attacked in 1996 in part because of political objections to practice guidelines regarding back surgery. Similarly, recommendations from MedPAC, particularly those that call for payment reductions, are also criticized regularly by stakeholders. Even so, an important point about such controversies regarding practice guidelines is they have been unusual. Several hundred new or revised practice guidelines are added every year to AHRQ’s National Guideline Clearinghouse which now catalogs about 2,400 guidelines, few of which have attracted any public concern.

So, why the controversy in this case? Comparative effectiveness research (CER) and evidence-based medicine (EBM) seem most likely to face challenges when findings call for some degree of “disinvestment”—reducing use of an established technology. The mammogram recommendations, like the back surgery guidelines 15 years earlier, involved replacing some uses of a technology with a more conservative approach. Health care providers and the public at large have an appetite for the new. Calls for doing less can be more difficult to accept. Even so, recommendations to do less do not necessarily generate controversy. For example, there was little public debate in 1996 when the USPSTF recommended against the use of screening asymptomatic persons for lung cancer with either low dose computerized tomography or chest X-ray.

The mammography guidelines had important economic implications for providers of the service in question—and indeed, there were some allegations that this was the primary source of the objections to the new guidelines—but several additional factors were also involved in the mammography case. One is the special nature of breast cancer, a disease that has generated a highly active advocacy community, many of whose members have long promoted screening mammography among women ages 40 to 49 based on the presumption that early detection saves lives. The research community has gone back and forth on the issue of screening for years, but this ambivalence had not always been reflected in the messages from the advocacy community. As one commentator put it, “Breast cancer is viewed as a plague. A ‘war’ on breast cancer is viewed as a crusade. Screening mammography is Excalibur.” The USPSTF recommendations differed from the long standing public health message advanced by several prominent advocacy groups, and they responded accordingly.

The response of the breast cancer community may also have been affected by the way the recommendations were developed and released. The Task Force is a private, non-governmental entity, and its meetings are not open. The release of the recommendations took place in a peer-reviewed journal that has rules against prior release of content. There was little awareness that the Task Force was seriously considering this particular revision of its breast cancer guidelines. Had there been, the Task Force might have received information that would have helped it to anticipate the shock the recommendations would produce and it could have worked more in advance to address possible misinterpretations, as it in fact did after the controversy blew up. (As the controversy raged, the Task Force reconsidered the matter and decided to stick with its recommendations, but with modified language.)

Another factor was that the Task Force’s recommendation was based on a particular weighing of the evidence. That is, it was possible to consider the evidence that the Task Force cited and come to a different conclusion. Deciding how much weight should be given to false positives and to the possibility that screening might detect some cancers that would never become life-threatening are matters of judgment, not fact. The Task Force decided that the risks of breast cancer screening of women younger than age 50 who carried no known special risk factors (e.g., genetic) outweigh the benefits of screening. Some advocates of screening, reviewing the same evidence, reached the opposite conclusion. Evidence that is less subject to conflicting interpretations may not produce the same defense of the status quo. But judgment about incommensurate factors will often be needed when evidence is evaluated.

Perhaps most important factor in this particular instance was the highly charged political environment into which the Task Force released its recommendations. Attacking the USPSTF and the mammography recommendations gave politicians an attractive way to advocate for women’s health. The recommendations also became part of the broader argument about the dangers of government control of health care. When the Obama administration had included $1.1 billion for CER in the stimulus package in early 2009, opponents warned that such research would be used by government to ration care and deny life saving treatments. Although USPSTF is independent, the recommendations by the Task Force are often adopted by public and private purchasers. In the context of the health reform debate, the recommendations were painted as a move toward government rationing of care and framed as “a glaring example of the dangers of increasing the federal government’s control of health care.” An online editorial published by The Wall Street Journal argued that this was an example of the “political rationing of care” that we can expect under “ObamaCare.”

Indeed, both the Senate bill (Patient Protection and Affordable Care Act - H.R. 3590) and the final reconciliation act adopted by both houses of Congress, “require qualified health plans to provide at a minimum coverage without cost-sharing for preventive services rated A or B by the U.S. Preventive Services Task Force.” Screening mammography for women ages 40 to 49 had received a rating from the USPSTF of “C,” so the charge that this recommendation could affect coverage was understandable. That helps to explain why Secretary Sebelius made her statement about the recommendations and why Congress included a provision in the health reform bill to disregard them.
Providing such opportunities for public comment may help the health services research community build support for basing policy decisions and practice guidelines on a strong evidence base and perhaps increase understanding of and confidence in the research base for such decisions. The new health reform legislation calls for establishment of a Methodology Committee to advise the Patient-Centered Outcomes Research Institute, which is charged with conducting CER. The Methodology Committee is required to “develop and improve the science and methods of comparative clinical effectiveness research.” Establishing the credibility of its methods among a broad array of stakeholders will not insulate the new Institute, or health services researchers more generally, from controversy. Nevertheless, establishing broader support for the value of health services research, coupled with sustained efforts to communicate more effectively with the public, is crucial as the United States grapples with how best to improve the quality and efficiency of its health system.

**Endnotes**

14. Virginia Hopkins wrote. “The controversy is all about those billions of dollars that won’t be flowing into the mammogram industry— the manufacturers, the hospitals, the clinics, the radiologists, the oncologists, the labs doing the biopsies, and so forth.” Hopkins, Virginia. 2009. “Mammogram Controversy—Follow the Money.” *Health Watchers’ News and Views.* November 18.
17. For example, after years of hope and hype, the use of high-dose chemotherapy with bone marrow or stem cell transplantation for the treatment of advanced and early-stage breast cancer was stopped once there was sufficient evidence that this approach did not work (http://www.cancer.gov/cancertopics/high-dose-chemo).
18. During a December 1, 2009 statement on the floor of the U. S. Senate, Senator Coburn claimed that seniors “are going to die sooner” as a result of health reform.
21. Patient Protection and Affordable Care Act (P.L. 111-148) with amendments included in the Health Care and Education Reconciliation Act of 2010 (H.R. 4872); Patient Protection and Affordable Care Act (H.R. 3590).
22. This provision does not state that recommendations with a grade below B should not be covered, but that is a reasonable interpretation.
Coalition Corner

Advocating for Health Services Research and Data

The Coalition for Health Services Research is the advocacy arm of AcademyHealth, working to educate policymakers and federal decision makers about the value of health services research (HSR) in transforming health and health care. Supported by a portion of AcademyHealth members’ dues, the Coalition advocates for members’ priorities to strengthen our field such as increasing funding for investigator initiated research and training grants to support the development of the next generation of health services researchers.

What Have You Done for Me Lately?
The Coalition has been busy this past year meeting with congressional and administration staff, attending briefings, submitting comments and letters to Congress and leaders of federal agencies, and working for the inclusion (or, sometimes, removal) of language in relevant legislation. Results of the coalition’s efforts to date include the following:

→ Helped secure $1.1 billion in funding for comparative effectiveness research (CER) through the American Recovery and Reinvestment Act (ARRA), of which $8.5 million has funded AcademyHealth member research; the $8.5 million represents 4.5 percent of the total amount of CER ARRA funding awarded thus far.¹

→ Secured approximately 10 percent funding increases for the Agency for Healthcare Research and Quality (AHRQ) and the National Center for Health Statistics (NCHS) in FY 2010, allowing both AHRQ and NCHS to preserve and restore core activities.

→ Provided language that was incorporated into House and Senate appropriations bills that targeted funding for investigator-initiated research at AHRQ. Additional language requested AHRQ to support a more balanced research portfolio, supporting all aspects of health care research outlined in its mission.

→ Ensured that CER provisions remained in the Patient Protection and Affordable Care Act, signed by President Obama in March 2010. The law provides an unprecedented mandatory funding stream for CER.

→ Modified health reform legislation that would have inadvertently restricted the publication of research findings generated under contract with a new CER entity.

The Coalition also helps AcademyHealth members by conveying news and information on the federal agencies that support HSR. For example, the Coalition recently produced a guide of what the new health reform legislation means for health services researchers. The document may be accessed at www.chsr.org/healthreform.

Talk the Talk…
The Coalition’s legislative term of the quarter is, “Deeming Resolution.” In years where Congress does not agree to a budget resolution to set overall caps on federal spending, a “deeming resolution” is adopted to specify the spending levels and allocations to the Appropriations Committees. Without such a resolution, there would be no effective cap on total spending that could be included in the appropriations bills, and the House and Senate could assume different levels of overall spending. At the time of this writing, the Senate Budget Committee has passed its FY 2011 Budget Resolution; it is unclear when the resolution will come to the floor of the Senate and the House has yet to act. It is likely that a deeming resolution will be included in the forthcoming war supplemental so appropriators may begin work on the FY 2011 spending bills.

Can I Get Involved?
Yes! We rely on AcademyHealth members to help us advocate for certain issues. For example, last year, we mobilized members in key states and districts to advocate for inclusion of CER funding in ARRA. As the FY 2011 appropriations season begins and the U.S. Department of Health and Human Services undertakes the Herculean task of implementing health reform, please look for emails from us about ways to get involved. You may also contact the Coalition at coalition@academyhealth.org.

Advoacy in Action!
The Patient Protection and Affordable Care Act authorizes Public Health Services and Systems Research (Sec. 4301) to optimize public health delivery. The Act also authorizes $500 million in both FY 2010 and FY 2011 to support a Public Health and Prevention Fund (Sec. 4002) to support programs authorized by the Public Health Service Act. The Coalition for Health Services Research collaborated with other national public health organizations to urge the Secretary of Health and Human Services to provide $50 million of this mandatory funding to support the newly authorized PHSSR program. A copy of the joint-letter is available at: www.chsr.org/policy.htm

* Source: Analysis of NIH RePORTER data, April 16, 2010.
AcademyHealth’s Career Center Can Help You

Whether you are looking for a new job or are preparing to take the next step in your career, AcademyHealth’s Career Center can help you find the opportunity that is right for you. Positions are categorized under the headings of faculty/university-related, researcher/non-faculty, health policy, and fellowships. The service is offered free to AcademyHealth members.

As an employer, you can effectively reach your target audience and recruit the most highly qualified candidates through AcademyHealth’s Career Center. Our Career Center brings your professional needs to the attention of a diverse membership composed of health services researchers, public policymakers, business decision makers, policy analysts, economists, sociologists, political scientists, consultants, clinicians, and students. Our Career Center is the largest single resource of position listings for health services researchers and health policymakers. It is widely reviewed by the industry’s top candidates.

Employers may submit advertisements online to begin recruiting from AcademyHealth’s diverse and talented membership. Employers that are AcademyHealth organizational affiliate members can post positions on the Career Center at a discounted rate.

AcademyHealth’s funding opportunities Web page has been expanded to provide members with a more comprehensive resource. You will find a list of funding opportunities and fellowships offered by federal government agencies and foundations. All funding opportunities are ordered by the date of posting on the Web site, making it easy to locate new funding opportunities.

Take advantage of AcademyHealth’s Career Center—find a job or fill a position—quickly and easily. And learn about a funding opportunity for your next research project.

News from the Journals

AcademyHealth’s official journals, Health Affairs and Health Services Research (HSR), provide updates on recent issues in health services research and policy. Subscription discounts are available for members. For more information, visit www.academyhealth.org/membership.

Health Affairs May Issue Examines Primary Care

Bold changes are needed in how the United States delivers and pays for primary care if the key goals of national health reform are to be achieved, according to the May issue of Health Affairs. This thematic issue of the journal examines the crisis facing the U.S. primary care system as well as promising solutions for reinventing primary care. Building a state-of-the-art primary care system, the issue concludes, is critical to achieving better health care, better value for the dollars spent, and expanded access for the tens of millions of Americans who will gain insurance coverage over the next few years.

Featured studies in the May issue include:

- An overview of the current landscape of U.S. primary care;
- The huge pay gap between primary care physicians and specialists;
- Analysis of the essential elements of the patient-centered medical home;
- The need to train physicians to be managers; and
- Practice profiles and case studies from around the country.

To access a full table of contents from this issue, visit http://www.healthaffairs.org/Content/Issues/2010/05/FAQ.xhtml.

HSR Theme Issue Call for Papers: Global Health Systems

Global health—the study of improving human health and achieving equity in health worldwide—has attracted the attention of key stakeholders including policymakers and politicians, international corporations, and international nongovernmental agencies. Likewise, research, policies, and financial resources have been increasingly focused on global health, most notably over the past decade. Yet as funding has grown, so has a consensus that we lack solid evidence about the effectiveness of efforts supported by such funding, particularly with regard to improvements in and impacts on health systems.

For this upcoming theme issue, HSR and Yale University are soliciting studies, evaluations, policy analyses, and simulations that use rigorous and scientific research methods to assess the impact of systems to improve global health, including delivery, financing, and regulatory systems.
Go Behind the Scenes of Health Policymaking in Washington

2010 Health Policy Orientation: October 25–28

The annual Health Policy Orientation gives participants an in-depth understanding of the formal and informal processes shaping the nation’s health policy agenda. With expert faculty members, group discussions, hands-on tutorials, and a congressional site visit, participants master the fundamentals of policy development and implementation and experience the Washington health policy environment with insiders.

The orientation is ideal for health policy fellows and analysts, public officials, federal or state government employees, private sector health care employees, and consultants. Space is limited to 50 participants for a nearly one-to-one ratio of participants to faculty.

The program reviews the essentials of health policymaking and provides diverse stakeholder perspectives on timely issues. Expert faculty members share their insights from their years of experience in advising the president, serving as staff to members of Congress, and administering federal health programs. The faculty also includes leading researchers, legal scholars, and public opinion experts.

The 2010 orientation is scheduled for October 25–28 in Washington, D.C. Registration opens July 15. Visit the orientation website at www.academyhealth.org/orientation for more information, or call Anna LaFayette at 202.292.6739.

This program is organized with support from the U.S. Centers for Disease Control and Prevention’s National Center for Health Statistics.