In today’s society, health care consumers are always seeking the “next big thing”: a pill they can take to alleviate one ailment or another, or an advance in medical research that will save lives, or at least prolong them. Many such solutions are linked to pharmaceutical or technological discoveries. But one surgeon asserts that health services research, not clinical science, should be viewed as the gateway to improved health.

Addressing more than 2,300 health services researchers, practitioners, and policy professionals at AcademyHealth’s Annual Research Meeting in Boston June 26. Atul Gawande, M.D., Ph.D., made the case that it is through the examination of health systems that health can be most improved.

“Research on our health care system can save more lives in the next decade than bench science, research on the genome, stem-cell research, cancer vaccine research, and everything else we hear about on the news,” Gawande said.

He explained that there is a gap in what medicine can do and what physicians actually do; the role of health services researchers in this equation is to try and understand how to narrow that gap. Gawande, who is both a physician and a health services researcher, acknowledged that while new innovations to expand knowledge and therapies are needed, getting this information to all those who can benefit from it is even more important. He used vignettes of past research, as well as personal experiences, to defend this view.

When the gene for Cystic Fibrosis was found in 1989, it was thought that a cure would only be a few years away. Unfortunately, scientists have been unable to determine how to eradicate the disease. The Cystic Fibrosis Foundation shifted some of its research investment into monitoring and improving the quality and organization of Cystic Fibrosis Centers. Examining how treatment is applied and whether or not patients are adhering to treatment protocols and medication is just as important as the development of...
With your help and support, the Coalition for Health Services Research—the advocacy arm of AcademyHealth—had an encouraging 2004. The Agency for Healthcare Research and Quality (AHRQ) saw its budget increase by $15 million to fund comparative effectiveness research. The National Center for Health Statistics received a $19 million increase, allowing the Center to maintain its current number of surveys, people interviewed, and questions asked. The increase was necessary to maintain the integrity of the data upon which health services researchers depend.

Halfway through the budget process for this year, we are already seeing some positive moves. The Senate Appropriations Committee funding bill would increase comparative effectiveness research at AHRQ by $5 million. The Committee has also recognized the importance of investigator-initiated research and is encouraging AHRQ to maximize its efforts to fund more of this critical research (for more information, see Coalition Corner, page 4).

Two major challenges remain for the 109th Congress. The first is the reauthorization of AHRQ. At its June 28 meeting, the AcademyHealth Board of Directors approved five recommendations for Congress to consider regarding the placement, funding, and coordination of health services research (see June 2005 issue of AcademyHealth Reports, page 4). The Coalition now will take those recommendations and attempt to translate them into policy. We have already begun this process by discussing the recommendations with key congressional leaders. We are also enlisting the help of the 135 organizations who are members of the Friends of AHRQ, the 25 members of the coalition that lobbies for more funding for comparative effectiveness research, as well as other stakeholders.

In addition to AHRQ reauthorization, the leadership of your Coalition recognizes that we need to develop a next generation of champions for health services research. Many of our champions have left or soon will leave the Congress including Senator Bill Frist (R-Tenn.), who will be retiring from the Senate after next year. Other supporters such as Arlen Specter (R-Pa.) and Tom Harkin (D-Iowa) will remain for the present, but their tenure as senior members of the Senate is uncertain. For this reason the Coalition leadership is working hard to identify members of the Congress who might champion the cause of health services research, provided we educate them about what we do and help them to understand the importance of investing in our field. In support of this goal, if you have a close relationship with a member of Congress, please be sure to contact Jon Lawniczak, our director of government relations, at jonathan.lawniczak@academyhealth.org.

Along with my colleagues on the Coalition Board, I will continue working hard to increase awareness and interest in health services research and, hopefully, to enhance its funding. We look forward to working with the membership of AcademyHealth in support of that goal.

David Abernethy
Chair, Coalition for Health Services Research

Dates to Watch

<table>
<thead>
<tr>
<th>Dates</th>
<th>Events</th>
</tr>
</thead>
<tbody>
<tr>
<td>October</td>
<td>2006 National Health Policy Conference registration opens</td>
</tr>
<tr>
<td>14</td>
<td>Winner(s) of the HSR Impact Award announced</td>
</tr>
<tr>
<td>November</td>
<td>2006 Annual Research Meeting Call for Abstracts issued</td>
</tr>
<tr>
<td>December</td>
<td>AcademyHealth Semi-Annual Board of Directors Meeting</td>
</tr>
<tr>
<td>21</td>
<td>Early registration deadline for 2006 National Health Policy Conference</td>
</tr>
</tbody>
</table>

If you have questions or comments about AcademyHealth Reports, our quarterly newsletter, please contact LeAnne DeFrancesco at leanne.defrancesco@academyhealth.org.
those medications. According to Gawande, it is a fundamental and important gamble that this shift from a focus on medical research to health systems research will save more lives, but it is the right one.

The role of performance failures, he said, has become increasingly important because in the last half century, science has given society so many things that medicine can do to treat illness and better people’s lives. Therefore, the decisions that those in medicine make—how they do even the smallest thing—suddenly matter. “What is interesting about medicine is its very ability to care for people, and the differences of what people get are meaningful,” he said.

“Research on our health care system can save more lives in the next decade than bench science, research on the genome, stem-cell research, cancer vaccine research, and everything else we hear about on the news.”

— Atul Gawande

To illustrate his point, Gawande conveyed results of an examination of the lethality of war wounds dating back to the Revolutionary War (see chart at right). He found that the likelihood that a soldier would die once he/she was injured has remained largely unchanged, despite advances in medical science. As recently as the Persian Gulf War, the lethality rate was around 24 percent, which is actually higher than in World War I (21 percent).

In the conflicts in Iraq and Afghanistan, however, the lethality rate has been cut in half; at least part of this success stems from health services research. For example, researchers discovered that despite the availability of Kevlar® vests, many soldiers weren’t wearing them. Soldiers have been more vigilant in the recent conflicts, however, and it has improved their chance for survival, simply because the vests protect against more life-threatening injuries and “buy time” for soldiers to reach medical attention.

Similarly, health services research has informed the development of Forward Surgical Teams, which travel with troops and do surgery right on the battlefield. They set up in one hour and are able to stabilize wounded soldiers so that they can make the trip to more comprehensive care. In Vietnam, 24 percent of the soldiers who died of their wounds died on the battlefield, but less than 3 percent died if they made it to an operating table. The likelihood that a soldier wounded in combat today will die is now under 10 percent. These dramatic improvements in survival rates, Gawande noted, are closely linked to system improvements and the research that underpins them.

“A lesson from watching medicine is that there is a distinct pattern to how things go when they go right and when they go wrong,” says Gawande. “We must pay attention to our results and failures, and ask ourselves, ‘What would you do differently?’ Health services research can help answer that question.

Webcasts of this and other presentations from the Annual Research Meeting are available at www.kaisernetwork.org.

Atul Gawande is a staff member of the Brigham and Women’s Hospital, the Dana-Farber Cancer Institute, and The New Yorker magazine. He practices surgery at Harvard Medical School, and is an assistant professor in the Department of Health Policy and Management at the Harvard School of Public Health. He is associate director of the Brigham and Women’s Hospital Center for Surgery and Public Health. His book, Complications: A Surgeon’s Notes on an Imperfect Science, was a finalist for the National Book Award in 2002 and has been published in more than 100 countries.

Lethality of War Wounds among U.S. Soldiers

<table>
<thead>
<tr>
<th>War</th>
<th># Battle-Wounded or Dead</th>
<th># Battle Dead</th>
<th>Lethality of War Wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revolutionary War, 1775–1783</td>
<td>10,623</td>
<td>4,435</td>
<td>42%</td>
</tr>
<tr>
<td>War of 1812, 1812–1815</td>
<td>6,765</td>
<td>2,260</td>
<td>33%</td>
</tr>
<tr>
<td>Mexican War, 1846–1848</td>
<td>5,885</td>
<td>1,733</td>
<td>29%</td>
</tr>
<tr>
<td>Civil War (Union Force)</td>
<td>422,295</td>
<td>140,414</td>
<td>33%</td>
</tr>
<tr>
<td>Spanish-American War, 1898</td>
<td>2,047</td>
<td>385</td>
<td>19%</td>
</tr>
<tr>
<td>World War I, 1917–1918</td>
<td>257,404</td>
<td>53,402</td>
<td>21%</td>
</tr>
<tr>
<td>World War II, 1941–1945</td>
<td>963,403</td>
<td>291,557</td>
<td>30%</td>
</tr>
<tr>
<td>Korean War, 1950–1953</td>
<td>137,025</td>
<td>33,741</td>
<td>25%</td>
</tr>
<tr>
<td>Persian Gulf War, 1990–1991</td>
<td>614</td>
<td>147</td>
<td>24%</td>
</tr>
<tr>
<td>War in Iraq/Afghanistan, 2001–present</td>
<td>14,823</td>
<td>1,401</td>
<td>9%</td>
</tr>
</tbody>
</table>

Budget Process Marches Forward

Both the House and Senate Appropriations Committees have met to “mark up” their bills providing funding for most agencies that fund health services research and send them to the floors of each chamber. As anticipated, in this tight budget year, funding for most programs are at last year’s level (see funding chart at www.chsr.org for more details).

The House committee funded the Agency for Healthcare Research and Quality at this year’s level of $319 million. The Senate committee, however, added $5 million to the $15 million awarded last year for comparative effectiveness research. These new funds from the Senate bill would bring the total for AHRQ to $324 million. While the Senate committee did not provide any new funds for investigator-initiated research, it did recognize that this research is diminishing at AHRQ and encouraged AHRQ to maximize its efforts to increase its funding (see box at right).

The National Center for Health Statistics remains at $109 million in both bills, which sustains last year’s increase of $19 million. Last year’s increase was necessary to allow NCHS to restore the number of surveys it conducts, and maintain the same number of interview subjects and questions. This is the second year of full funding for the Centers for Disease Control and Prevention’s Public Health Research initiative. Again, both the House and Senate supported continued funding for this program.

The Centers for Medicare and Medicaid Services’ (CMS) Office of Research, Development and Information, which was funded at $28 million last year, receives $65 million in the House bill and $78 million from the Senate. The Senate requires that most of this increase—$40 million—be spent on Real System Change Grants, a program eliminated in the President’s budget request. It is unclear if the remaining $10 million increase is earmarked for projects Congress wants to fund, or if CMS will be able to program the funding as it sees fit.

The next steps in each chamber will be to send their respective bills to the floor for debate and final action. Once the bills are passed, a conference committee consisting of House and Senate members will meet to iron out the differences between the two bills.

Investigator-Initiated Research

The Senate Appropriations Committee notes that the Department of Health and Human Services (HHS) reallocated $11,518,000 from AHRQ in fiscal year 2005 to fund HHS’ health information technology initiative. While the Committee strongly supports this initiative, it notes that this reallocation delayed the start of several non-patient safety grant programs.

Research outside of targeted areas such as patient safety, health IT, and comparative effectiveness is a critical part of AHRQ’s mission, yet these grants are a diminishing portion of the agency’s research portfolio. The Committee notes that important initiatives like the patient safety program were based on investigator-initiated research. The Committee strongly urges AHRQ to maximize investigator-initiated research.

Taken from Senate Report 109-103 to accompany the Departments of Labor, Health, and Human Services, and Education and Related Agencies Appropriations Bill, 2006.

AcademyHealth and NCHS Name 2005 Health Policy Fellows

The Centers for Disease Control and Prevention’s National Center for Health Statistics (NCHS) and AcademyHealth are pleased to announce the selection of Lisa Lyman and Richard Kronick, Ph.D., as the recipients of the 2005–2006 NCHS/AcademyHealth Health Policy Fellowship. In its fourth year, the fellowship provides researchers access to the rich data resources at NCHS, offers opportunity to use these data in conducting HSR projects, and strengthens their understanding of health policy. Fellows work in residence at the NCHS in Hyattsville, Md., on their proposed research projects, as well as on collaborative projects with NCHS staff.

Ms. Lyman will begin her fellowship in fall 2005. She is a Ph.D. candidate/NIMH pre-doctoral fellow at Johns Hopkins University. The purpose of her project, Depression Symptoms, Poverty, and Single-Parenthood: Effects of Maternal Factors on Children’s Use of Preventive Health Services, is to determine the individual and combined effects of maternal depression, poverty, and single-parenthood on the adequacy of utilization of prenatal care services and preventive health services for children during the first three years of life.

Dr. Kronick will also begin his fellowship in fall 2005. He is a professor at the University of California, San Diego. The purpose of his project, Estimating the Effects of Health Insurance on Quality Adjusted Life Years, is to improve estimates of the effects of insurance on health.

The NCHS/AcademyHealth Health Policy Fellowships run from 13 to 24 months, beginning each fall. They are offered to up to two individuals who may be at any stage in their careers, from doctoral students in their dissertation phase to senior investigators. For information on the next cycle, visit www.academyhealth.org/nchs.
Report Examines Barriers to Diversity in HSR Workforce

While many universities and health services research (HSR) programs are dedicated to increasing opportunities for ethnic minority groups or underrepresented individuals (URIs)—African Americans, Hispanics, Asians, American Indians/Alaskan Natives—these individuals continue to be poorly represented in the health professions in general, and in HSR in particular. According to 2002 U.S. Census data, ethnic minority groups comprise nearly 29 percent of the U.S. population. Without adequate representation of the United States’ racial composition among health services researchers, decision makers find it more difficult to guide research agendas and devise policies that accurately reflect the nation’s needs.

With support from the W.K. Kellogg Foundation, AcademyHealth conducted a study of diversity in the HSR workforce. The study consisted of qualitative and quantitative research among faculty and students of 10 HSR doctoral programs at public and private institutions. The study report, Racial and Ethnic Diversity in Health Services Research: Pockets of Progress but a Long Way to Go, provides an understanding of the barriers to a diverse HSR workforce and yields concrete strategies for overcoming them.

Barriers to Diversity in HSR

The study identified barriers to URIs entering, staying, and succeeding in HSR. Among the faculty interviewed, the most frequently mentioned barriers were competition between HSR and other fields, student qualifications, and program and university-wide constraints, such as lack of funding, lack of URI faculty and role models, and lack of time needed to recruit and mentor students. Faculty also mentioned that the political, social, and legal climates (e.g., efforts to repeal affirmative action programs) may affect university and/or program admissions policies.

The first significant barrier identified by students was limited prior knowledge of HSR both as a degree and as a field of work. When asked how they decided to pursue an HSR degree, most students responded that they found HSR almost accidentally when looking at health-related programs. Many students were already working in the field but did not know it was called HSR. Second, HSR role models are limited both within the educational context and within the field. As a result, HSR is not being recommended to potential students.

Third, students identified inconsistent institutional connections as a barrier. Faculty connections to a student’s area of interest are important to admissions but also to the level of support received during the programs. Finally, the institutional support system varies. URIs feel it is easy to “fall through the cracks” and question whether mentors would be able to provide much needed support.

Overcoming Barriers to Diversity in HSR

Best practices identified through this year-long study include the importance of overcoming barriers to diversity in the HSR workforce through a multifaceted approach that involves higher education institutions, faculty, and students.

Some of the best practices for HSR institutions are:

- Encourage higher education institutions to develop a clear statement on the importance of diversity and to establish subsequent measurable outcomes for diversity.
- Collect data by race and ethnicity to report URIs’ participation in HSR.
- Encourage higher education institutions to recruit underrepresented faculty and elevate these faculty into visible and influential decision-making positions.
- Market HSR to students early in their careers through summer programs or internships, and reach out to students from a variety of disciplines.
- Reduce the financial and non-financial burdens associated with pursuing a career in HSR by contacting admissions officers about HSR funding opportunities and reaching out to federal government agencies and foundations.

Applying these suggested best practices at both program and university levels will increase the exposure of HSR as a viable career option and will also increase awareness of the importance of diversity within the HSR field as a whole. As diversity increases in HSR, more URIs will have the opportunity to ascend to leadership at the national, state, and local levels in both the public and private sectors, thereby creating more role models and influencing the research and policy agendas that shape the nation’s health care system.

Read the report at www.academyhealth.org/diversity/index.htm.
International Program Focuses on Nurse Recruitment

The rapidly growing demand for nurses in the care of the sick and disabled, as well as in the promotion of health, exceeds the available global supply. Developed countries like the United States have to rely on many more nurses than they produce, and increasingly depend upon nurses recruited from less developed countries.

AcademyHealth and the University of Pennsylvania organized an expert meeting to review the evidence base on the causes and consequences of the global nurse shortage and to examine strategies to mitigate its negative impact on the health of people around the world. The meeting, which was held in July at the Rockefeller Foundation's Bellagio Conference Center in Italy, drew on case studies that were commissioned on Jamaica, the Philippines, India, China, Canada, the United Kingdom, and the United States, as well as two regional papers on Sub-Saharan Africa and the Caribbean.

In the United States, 11 percent of nurses are currently foreign-born. However, these figures are likely to rise. With an expected nurse shortage of 800,000 by 2020, hospitals are increasingly looking abroad to resolve staffing needs. The paradox is that thousands of qualified nursing school applicants are turned away each year in the United States, and there has been little debate in policy circles as to how to increase self-sufficiency of the American nurse supply.

The impact of this situation varies by region. Countries such as Canada, the United Kingdom, and Australia are losing nurses to the United States and are deeply concerned that active recruitment by U.S. hospitals will further exacerbate their own shortages. India, China, and the Philippines are able, at least in theory, to produce more health workers than they can currently employ. Some representatives from these countries believe that as long as the migratory flow is steady and can be anticipated, there are many positive effects of migration, including remittances back to the originating country, as well as expanded educational and work opportunities abroad.

The greatest problem lies in the Caribbean and Sub-Saharan African countries where, particularly in Africa, the HIV/AIDS epidemic has already devastated the health workforce. The World Health Organization recommends a minimum of 500 nurses per 100,000 people; nurse population ratios are as low as 50 per 100,000 in many African nations. In addition, there is an exodus of double-to-triple the number of nurses these countries are able to train per year.

AcademyHealth will continue its focus on international health worker migration at the 2006 Health in Foreign Policy Forum on February 8, held in conjunction with the National Health Policy Conference (see article on page 8 for more details).

Get Involved: Vote in AcademyHealth’s Board Election

September is the time to help shape the leadership of AcademyHealth in its upcoming board election. Members can cast their electronic votes for new Board members between September 6 and 23. Voting instructions were sent by e-mail and postal mail September 6. AcademyHealth individual members who are active as of August 1, 2005, are eligible to participate.

In this election, there are six candidates who were chosen by AcademyHealth’s Nominating Committee; the three who receive the most votes will join AcademyHealth’s Board of Directors. They will serve four-year terms beginning December 2005.

In selecting the six candidates, the Nominating Committee’s goal was to bring diversity and expertise to the board and strike a balance between continuity and new leadership.

This year’s nominees are:
- David Blumenthal, Director, Institute for Health Policy, Massachusetts General Hospital/Partners HealthCare System
- Robert M. Mayberry, Director, Program for Healthcare Effectiveness Research, Morehouse School of Medicine
- Carmen R. Nevarez, Medical Director & Vice President of External Relations, Public Health Institute
- Michael A. Rodriguez, Associate Professor of Family Medicine, David Geffen School of Medicine, UCLA
- Joseph Thompson, Arkansas Chief Health Officer and Associate Professor, University of Arkansas College of Medicine
- Mary K. Wakefield, Associate Dean, University of North Dakota School of Medicine and Health Sciences

Biographies and photos of the candidates are available at www.academyhealth.org/membership/memberelected.htm.

Per the AcademyHealth bylaws, the number of member-elected and Board-elected candidates should be approximately equal each year. This year there are three member-elected Directors and two Board-elected Directors. On June 9, the Board selected S. Anthony (Tony) McCann, Secretary, Maryland Department of Health & Mental Hygiene, and Louis F. Rossiter, Director, The College of William and Mary’s Thomas Jefferson Program in Public Policy, to join the AcademyHealth leadership. For more information on these individuals, visit www.academyhealth.org/membership/boardelected.htm.

We encourage all individual members to participate in the September election. Every vote can make a difference.
members matter

Interest Groups Convene at Annual Research Meeting in Boston

AcademyHealth’s 10 Interest Groups (IGs) held pre- and post-conference programs in conjunction with the Annual Research Meeting (ARM). In total, 600 participants attended the meetings that featured more than 100 speakers in 31 panels as well as more than 120 poster presentations. Specifically designed to be smaller and more intimate, the IG meetings allow members to share work that might not otherwise be presented during the main ARM program.

The programs for these meetings were developed largely by members and provided outstanding opportunities for in-depth exploration of specific topics. For example, the Public Health Systems Research IG had a lively discussion about the barriers to high-quality methods for the field and the availability of reliable and useful public health data. The group agreed there is a need for better access to existing data sets as well as more and better state-level data. As a result, the IG will consider collecting members’ data needs and priorities and use this information to advocate for the funding needed to build this important infrastructure.

The Health Economics IG pay-for-performance (P4P) panel generated discussion on whether this new, relatively untested initiative will lead to higher quality and/or more efficiency in the health care system. The audience questioned the magnitude of payment for performance needed for the incentive to be able to affect quality or efficiency. There appeared to be consensus that it will likely depend on the design of the reward system and how much is at stake for providers. Many are waiting to see whether P4P efforts in the Medicare program produce desired results, given the program’s considerable market share.

The State Health Research and Policy IG used case studies to focus much of its meeting on “real life” examples of how research and policy are integrated and implemented. One case centered on Rhode Island’s formation of a Research and Evaluation Workgroup to build a research program component within their Medicaid program. The Workgroup is a good example of successful collaboration between academic researchers and Medicaid program staff and program administrators. The State IG meeting also featured a poster session that included presentations on state-level research focusing on data collection and analysis. This session provided an opportunity for these researchers to share their findings with others who often work in similar settings but do not have many opportunities to connect with researchers from other states.

In general, poster programs proved to be a popular element of many of the meetings. Hosted during lunch or a reception, the poster sessions featured more than 120 presentations and provided extended time for networking and individual conversations with a variety of researchers.

To see agendas and presentations from the meetings, visit www.academyhealth.org/arm/adjunct/interestgroups.htm.

News from the Journals

Health Affairs
Health Affairs’ September/October issue studies information technology issues, with estimates of the savings that could occur in the health care system with greater use of IT, along with discussions surrounding adoption of IT, and interviews with federal health IT Coordinator David Brailer. The November/December issue is devoted to health care reform issues, with analyses on the future of health insurance, market competition, and improving population health.

HSR
Health Services Research features a special issue on “Measurement challenges in health services research: population, setting, and methodology considerations” in October 2005 Part II (40:5 Part II). This special issue reviews how measurement is influenced by special population and system issues, using the VA health system as an example. It includes articles on measurement in health disparities research, the categorization of race and ethnicity, measurement validity and use in clinical settings, the use of ICD codes, proxy respondent issues, and computer adaptive testing in the assessment of outcomes.

Milbank Quarterly
Using the example of the quality-reporting system for long-term care, the first article of the fall issue of the Milbank Quarterly examines whether the public disclosure of information about the quality of health care providers yields reliable evidence, stimulates doctors to provide better care, and serves the interests of patients as consumers. Other topics explored in this issue include the question of whether the number of older Americans with disabilities is declining; how and why the association between objective and self-rated health changes with age; how policies for caring for the seriously mentally ill might be integrated into general health policy; and the positive impact the availability of primary care has in the overall health status across populations.
Migration and the Global Shortage of Health Workers

AcademyHealth’s 2005 Health in Foreign Policy Forum presented an overview of the many U.S. health policy challenges that have international implications. The 2006 Forum will focus on an issue that literally crosses borders: health worker migration. The Forum, which builds upon the July 2005 AcademyHealth international expert meeting on nurse migration in Bellagio, Italy, will examine the causes, consequences, and possible domestic and foreign policy responses to the global shortage of nurses and physicians.

U.S. shortages directly affect the health workforce shortages in both rich and poor countries around the world. Seventy percent of foreign nurses and physicians in the United States come from developing countries, most of them English-speaking nations of Africa, the Caribbean, and Southeast Asia. Thirty percent of the U.S. health workforce comes from other developed nations, such as Canada, the United Kingdom, and Australia. These same countries also recruit internationally to resolve their shortages, further exacerbating the health worker shortages in developing countries.

While the complexities of health workforce shortages and international recruitment make a single solution impossible, there is an urgent need to bring together domestic health and foreign policy experts to explore complementary policies that can be tailored to specific regional situations. These two sectors rarely coordinate, but in this case, the absence of dialogue means that domestic practices threaten to undermine foreign aid objectives. This Forum proposes to begin a dialogue around a shared goal: building health workforce capacity in this country and abroad.

For more information on the 2006 Forum, visit www.academyhealth.org/nhpc/foreignpolicy/index.htm.

Reader Survey Results

With a 35 percent response rate, AcademyHealth members provided valuable feedback on AcademyHealth Reports through an online reader survey conducted in March. Several themes emerged from the responses, including positive opinions of the lead feature article for each issue, as well as information on upcoming activities and updates from our journal partners. We also learned that this publication needs to provide information you don’t get other places.

How are we changing this publication? Not a great deal. Since most readers were generally pleased with the content and length of AcademyHealth Reports, we will continue to provide feature articles, legislative updates, and alerts on upcoming events.

One change you will see beginning with this issue is that we have found a new home for the “Moving On and Moving Up” column that features members’ career changes. This is now located on our Web site in the members only section at www.academyhealth.org/membership/membersonly.htm. In the coming months you will also see changes in the “News from the Journals” column as well as regular features on the activities of our Interest Groups.

We thank all the members that participated in this survey. Your feedback is important as we strive to provide you information and benefits that meet your needs.

The full survey report is available online at www.academyhealth.org/membership/membersonly.htm.