HEALTH CARE: HERE OR TO GO?

A home delivery option is a type of consumer service that characterizes many different kinds of business sectors. Placing a telephone call to a pizza store makes it possible for the individual at the other end to say hello, greet you by name, ask if you want a large pizza with the same toppings as bought last week, and whether the purchase is for pick-up or home/office delivery. Health care is moving in a similar direction in the production of such capabilities, but not at the same pace. Despite the widespread use of electronic health records, for example, there still are major challenges to achieve interoperability among different providers of care.

Meanwhile, patients and their caregivers at home appear poised to make great leaps forward in using technology in efforts to improve health status. A survey of cancer caregivers reported in the November 2015 issue of the journal Telemedicine and e-Health reveals that most caregivers have high access to and use of technology. Because age has been associated with technology use, responses were compared between geriatric (≥ 65 years old) and non-geriatric (18–64 years old) respondents to determine receptivity to technology-based tools to augment their caregiving roles. Although non-geriatric caregivers expected to derive more benefit from such tools, both groups believed that caregiving technologies could ease burden or distress. Studies of this nature indicate that a substantial number of early adopters are waiting for new forms of technology to become accessible.

According to the firm Accenture Consulting, on-demand is in demand. Consumers are yearning for convenience, simplicity, speed, and immediate satisfaction. A deluge of digital first companies are answering the call, offering closed-loop, human delivered experiences to consumers in near real time. Health used to be at the back of the pack, but as the second fastest growing on-demand segment, it currently represents about one-fifth of total on-demand investment funding. Visits by video can be completed through organizations such as Doctor on Demand, which connects with board-certified physicians via smartphone or tablet. Online, virtual therapies are another kind of on-demand services available through sites and apps, such as TalkSpace.

Oftentimes, technologies appear on the scene prior to the development of a comprehensive understanding of their various ethical and legal ramifications. A current example is the use of personal and commercial drones where a particular concern is that they not collide with airplanes in flight. Government regulations are being formulated for the purpose of preventing such disasters from occurring. The health care industry already is rife with fraud and abuse. Both consumers and payers of health care services will need to be furnished with protection from fraudulent schemes. Academic administrators and faculty also may have to give some thought to considering ways in which classroom preparation and clinical training might have to be modified to take into account the growth of on-demand job opportunities for health program graduates.
Dear Colleagues,

As you read this issue of *Trends*, we will be starting the month of March. Super Tuesday kicks off March in 2016 and we look forward to daylight savings time, signs of spring, and of course March Madness. There are other, perhaps less thought of, important markers within the month of March that are worthy of mention. March also begins with Zero Discrimination Day, a global observance established in 2014 promoting diversity and the importance of every individual. Do you know the symbol for Zero Discrimination Day?

March is National Women’s History Month, a recognition that is in its 29th year. This year recognizes 16 women who have made significant high impact contributions to the world in which we live. Can you name any of these women? See [http://www.nwhp.org](http://www.nwhp.org). Our Association’s leaders help shape ASAHP’s history and therefore it seems fitting, during women’s history month, to recognize the women who have served as our past ASAHP Presidents: Helen K. Hickey (1979); Polly A. Fitz (1982, 1984); Judith T. Barr ((1994-96); Diane M. Roberts (1996-98); and Linda C. Hatzenbuehler (2007-09).

March for ASAHP signals the time to make your arrangements for the *Spring Meeting*. We can thank the Association’s Secretary, Ruth Welborn, who has functioned as the 2016 spring meeting program planner for a schedule of sessions that are focused on important issues that every one of us and our member institutions are facing. The meeting will set the stage for our conversations that we have together. Our program will focus on issues facing allied health education and practice. We will hear about the current state of higher education reform in Washington, healthcare leadership, building strong and mutually beneficial collaborations with our corporate partners, competing for federal research funding, and addressing our responsibility in building strategies that will increase the diversity necessary in our allied health education. Oh, and of course, an always highly valued part of the meeting centers around the collegiality and the support we gain from each other. As such, we have great fun planned around another annual March event, St. Patrick’s Day in Louisville, with a reception sponsored and hosted by our important corporate partner, Kindred Healthcare!

Yes, March is busy for all of us and I urge you to put on your calendar the ASAHP’s Spring Meeting “A View from the Corner Office: Future for Allied Health Education, Practice, and Diversity.” Join 80-100 attendees who will come together March 17-18 in our host city, Louisville, Kentucky. While you have your calendars open, place a hold on the 2016 Annual Conference that will be held on October 19-21, 2016 at the Royal Sonesta Hotel, New Orleans. Enjoy the month of March and I look forward to seeing you in a couple of weeks in Louisville.

Warm Regards, Linda

ASAHP BECOMES A MEMBER OF IPEC

The Association became an Institutional Member in February 2016 of the Interprofessional Education Collaborative (IPEC), the premier interprofessional and practice organization focused on coordinating health professions education. Founded in 2009, IPEC holds multiple gatherings each year focused on interprofessional learning experiences to help prepare health professionals to provide better team-based patient care. ASAHP has been strongly supportive of the IPEC’s mission as an IPEC Supporting Organization to date and looks forward to working with IPEC as an Institutional Member in support of sharing best practices, as well as the creation of patient-centered, community and population oriented, interprofessional, collaborative practices.
LEGISLATIVE EXPECTATIONS IN 2016

Since 2016 is a presidential election year, hopes are not running high that much in the way of significant legislation will be passed that can make it to the enactment stage. A major reason is that the political party that is not in power is hesitant to give the party in power bragging rights for achieving great accomplishments. Conversely, the party in power usually finds it relatively easy to portray the party not in power as a convenient scapegoat playing its typical role by obstructing progress. Nevertheless, the year still is young and it never is clear what eventually might unfold that could benefit the populace.

On the plus side, although the National Institutes of Health received an increase in funding for the current fiscal year, unfortunately appropriations for the past several years have not kept pace with inflation, limiting the awarding of research funds. This deficiency has been especially acute for young investigators. The nature of the problem resulted in some remedial action proposed by the Senate Health, Education, Labor, and Pensions (HELP) Committee in the form of the bipartisan Next Generation (NextGen) Researchers Act (S. 2014). The measure was approved by a voice vote on February 9 of this year.

The legislation would create the “Next Generation Researchers Initiative” at the NIH to coordinate all current and new NIH policies aimed at promoting opportunities for new researchers and earlier research independence. The bill also directs the NIH to consider recommendations from a National Academy of Sciences (NAS) comprehensive study and report on fostering the next generation of researchers that was included in the recently passed Consolidated Appropriations Act. The proposed legislation would increase the amount of loans that can be forgiven through the NIH’s loan repayment program, as recommended by the NIH’s Physician-Scientist Working Group.

Once unanimous approval of the first set of medical innovations legislation was achieved, the HELP Committee issued an agenda for its second innovations markup that is scheduled to be held on March 9. The following bipartisan items will be considered: Advancing Hope Act of 2015 (S. 1878), Medical Electronic Data Technology Enhancement for Consumer’s Health (MEDTECH) Act (S. 1101), Medical Countermeasures Innovation Act of 2015 (S. 2055), Combination Products Innovation Act of 2015 (S.1767), and the Advancing Breakthrough Medical Devices for Patients Act of 2015 (S.1077). Moreover, committee members are amenable to adding more bipartisan proposals at a later date.

The topic of annual appropriations for FY 2017 is under consideration by committees in the House of Representatives where hearings were conducted in February.

2016 ASSOCIATION CALENDAR OF EVENTS

March 15-16, 2016—Leadership Development Program in Louisville, KY—Part I

March 17-18, 2016—Spring Meeting in Louisville, KY

October 17-18, 2016—Leadership Development Program in New Orleans, LA—Part II

October 19-21, 2016—Annual Conference in New Orleans, LA
AFFORDABLE CARE ACT DEVELOPMENTS

The Affordable Care Act (ACA) that became law in March 10 represents a series of initiatives that not only are enormous in scope, but exceptionally influential in steering overall developments in the health arena. Since providers in the form of health personnel and facilities, along with patients are affected in multiple ways by this legislation, an aim of this newsletter is to inform readers of events that may be of interest.

It should come as no surprise that the ACA has large numbers of supporters and detractors. Since not a single Republican in either congressional chamber voted in favor of this major piece of health reform, right from the start it was a foregone conclusion that efforts by members of that political party would be geared toward undermining this law. The most recent example of this intention being operationalized was an overall repeal bill sent to President Obama at the beginning of 2016. No less surprising is the fact that he promptly vetoed it. Since there are not enough Republicans in either the Senate of the House to override the veto, the law remains intact.

Enacted legislation of any kind represents a hope that its outcome will be as originally intended when it still was on the drawing board. Much of what was included in the ACA has since come to pass, but with some modifications that inevitably tend to occur in various implementation stages. An example follows:

**Recovering Funds From CO-OPs That Failed**

One portion of the ACA led to the creation of 24 nonprofit insurance cooperatives (CO-OPs). The purpose was to lower prices in the health insurance market by challenging the dominant role played by large insurance companies. More than $1 billion was loaned to the 13 of them that later failed. An effort is underway by the Centers for Medicare and Medicaid Services (CMS) to recover this money, but it still is too early to predict what the amount will be.

As with other elements in the law, Republicans have pointed out why either all or portions of it should be repealed because it cannot work properly. Democrats who support the ACA complain that the reason why this initiative failed is that not only did Congress remove approximately $4 billion of the $6 billion needed for proper implementation, Republicans added restrictions that had a negative impact on the risk corridor program that was designed to limit insurers’ losses.

**Section 1322 Medicaid Waivers Program**

Some debates between liberals and conservatives hinge on the topic of the role of the federal government in American life. Some critics assert that the nation is plagued by too many top-down policies that are directed from the nation’s capital. An antidote to that way of thinking is present in one aspect of the ACA known as the Section 1322 Medicaid Waivers Program. It takes into account the enormous amount of diversity in the 50 states from the standpoint of the kinds of patients and the nature of the benefits made available to participants in the Medicaid program, which is a federal-state venture that began to be implemented 50 years ago.

States have several options for modifying their approaches to providing health coverage to individuals and families. They have more latitude to decide how they want to increase transparency, improve quality, expand access to services by patients, and manage expenditures. One area in which these jurisdictions are taking advantage of waiver opportunities is in their managed care programs.
TRENDS

DEVELOPMENTS IN HIGHER EDUCATION

Federal View Of The Role Of Accreditation On Student Outcomes

For more than half a century, the accreditation process has sought to help colleges and programs set standards and continuously improve the education they provide. Accreditation is one stamp of approval the U.S. Department of Education requires as a way of ensuring that an academic institution offers a solid investment of public dollars before it is eligible to receive federal student aid. While this system is meant to focus the higher education field on quality, it is all too clear from this perspective that more must be done to address substandard and underperforming institutions; variations in quality and student outcomes; and the challenges facing today’s more diverse group of students.

Hence, accreditors’ evaluations increasingly must place a premium on student outcomes. Although the Department does not intend to impose specific standards on institutions, it wants to ensure that accreditors establish and enforce strong and meaningful outcome standards evaluated by the Department that effectively address educational quality, including student achievement. Agencies need to do more than certify that institutions make quality offerings available. They must gauge the extent to which the institutions actually help more students achieve their goals.

In November 2015, the Department announced a set of executive actions and legislative proposals to improve accreditation, along with transparency and accountability. Steps that will be taken to achieve these goals include: (1) Requiring and sharing publicly when possible more information from accreditors on why institutions were placed on probation, placed on warning, or found out of compliance with one or more of the accrediting agency’s standards. (2) Clarifying the flexibility agencies have to differentiate review processes for institutions, with guidance on specific standards and criteria that accreditors could use to strengthen their focus on outcomes.

Counterpoint On The Federal Role In Accreditation

In the first report in a new series on college completion from The Century Foundation, a focus is on questioning the recent push by government officials to have accreditors focus more on student outcomes. It examines how government officials have pressed college accreditors to focus more on “student outcomes”—quantifiable indicators of knowledge acquired, such as skills learned and degrees attained. The report then argues that it is not these enumerated outcomes that are the best way to hold colleges accountable, but rather the evidence of student engagement in the curriculum—their papers, written examinations, projects, and presentations—that holds the most promise for spurring improvement in higher education.

Furthermore, this engagement is also a key factor in keeping students in school all the way to graduation. The report concludes that reformers seeking to enhance college performance and accountability should focus not on fabricated outcome measures, but instead on the actual outputs from students’ academic engagement, the best indicators of whether a college is providing the quality teaching, financial aid, and supportive environment that make higher learning possible, especially for the disadvantaged. The report is on the Web at http://apps.tcf.org/the-real-value-of-what-students-do-in-college.

Reauthorization of the Higher Education Act (HEA) is long overdue. Apropos of comments made on page three of this issue of the Association’s newsletter TRENDS, it appears highly unlikely that action will be taken on this important piece of legislation. A key aspect of it pertains to accreditation. Notions contained in the aforementioned paragraphs of this article are bound to be among the many items that will be addressed when the reauthorization occurs.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Treatment Of Adults For Chronic Health Conditions
One in four Americans received treatment for at least two chronic health conditions such as diabetes and hypertension in 2012. Collectively, chronic care treatment accounted for 57% of all health care expenditures that year. According to the Medical Expenditure Panel Survey (MEPS), an estimated 25.9% of adults have two or more treated chronic conditions and they account for 57% of all health care expenditures. Of adults ages 18-44, 94.4% have no treated chronic conditions or only one treated chronic condition. Among adults age 65 and older, only 34.4% have no treated chronic conditions or only one treated chronic condition. Of adults age 65 and older, 42.3% have 2-3 treated chronic conditions and 23.2% have 4 or more treated chronic conditions. Average total health care expenditures were higher for adults with 2-3 versus 0-1 treated chronic conditions within each of the age groups for all three race/ethnicity groups.

Health Care Expenditures By Patient Group
A recent Medical Expenditure Panel Survey Statistical Brief indicates that among the U.S. non-institutionalized population in 2013, the 1% of Americans with the highest health care expenses accounted for nearly 22% of the nation’s total health care expenditures. Members of that group had annual average expenses of $95,200. In 2013, the top 1% ranked by their health care expenses accounted for 21.5% of total health care expenditures with an annual mean expenditure of $95,200. Overall, the top 50% of the population ranked by their expenditures accounted for 97.1% of overall health care expenditures, while the lower 50% accounted for only 2.9% of the total. Individuals age 65- and older were characterized by substantially less concentrated levels of health care spending relative to their younger counterparts. Alternatively, the elderly had the highest mean levels of health care expenditures relative to younger population subgroups at the top quantiles of the expenditure distribution.

HEALTH TECHNOLOGY CORNER

Engaging Patients Through Open Notes
According to BMJ Open, historically, patients have had little or no access to their own medical records. Technical issues and security and privacy concerns have been roadblocks, as has providers’ concern that such information might “scar” patients. Launched in 2010 in Boston, rural Pennsylvania, and Seattle, the rapidly expanding OpenNotes movement is allowing more and more patients real-time, unfettered online access to their clinical notes. Early evaluations were positive, both from patients’ and providers’ perspectives. A study, conducted five years later, found the program helps to deepen trust between primary care providers and patients while increasing patients’ understanding of their health and improving their ability to take care of themselves. Concerns about privacy appear to be relatively minor. The program is now being extended to specialists, mental health providers, and physical therapists.

Bioresorbable Silicon Electronic Sensors For The Brain
A team of neurosurgeons and engineers developed a brain sensor that monitors pressure and temperature in patients with traumatic brain injuries and then dissolves a few week’s later into the body’s own fluids. Every year, more than one million patients in the U.S. go to the emergency room with traumatic brain injuries that often cause swelling in the brain that constricts the flow of blood and oxygen and can lead to permanent damage. Large sensors that can monitor the brain are in use now, but they are invasive and can impede physical therapy. They also must be removed after the patient has recovered and carry risks of allergic reactions, infection, and hemorrhage. The new sensor is smaller than a grain of rice and incorporates dissolvable silicon technology developed at the University of Illinois at Urbana-Champaign as reported in an article in January 2016 in the journal Nature.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Children Of Immigrants

A new Issue Brief from the Urban Institute indicates that from 2006 to 2013, the number of children of immigrants (defined as children with at least one foreign-born parent) in the United States grew 12%, from 15.7 million to 17.6 million. In the United States, 24% of children have at least one immigrant parent. Over that same period, children of immigrants accounted for all growth in the U.S. population of children under age 18. The number of children of native-born parents fell 1.3 million, while the number of children with at least one immigrant parent increased 1.9 million. The Brief can be accessed at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000616-Children-of-Immigrants-2013-State-Trends-Update.pdf.

Improving Medication Adherence

Increasing medication adherence is critical to improving patient health outcomes and provider performance on value-based care and related quality initiatives. Many quality measures in the Centers for Medicare and Medicaid Services’ (CMS) value purchasing programs are influenced by medication adherence. Some measures capture adherence directly. For example, controlling hypertension and blood sugar, quality measures for accountable care organizations (ACOs) and Medicare Advantage plans, improves with higher levels of medication adherence. CMS also directly measures and rewards medication adherence for three conditions (diabetes, hypertension, cholesterol) under Medicare health plans that cover both Part C and Part D benefits and standalone Part D plans. Deloitte’s 2015 Survey of U.S. Health Care Consumers finds that adherence is associated with consumers’ attitudes about the health care system, wellness, engagement with digital tools, and individuals’ positive attitudes about the value of incentives in health plan offerings. The report can be accessed at http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-medication-adherence-022516.pdf.

Evidence-Based Coordinated Care For Seniors Is Elusive

Medicare beneficiaries with multiple chronic conditions spend what amounts to one month each year in a doctor's office, hospital, or some other healthcare venue, but often do not receive well-coordinated or evidence-based care, according to a new study from the Dartmouth Atlas Project. This report, supported by The John A. Hartford Foundation, explores the care experienced by older adults in the U.S., including the number and types of care providers they see, along with the frequency with which they have contact with the health care system. It identifies areas where improvements are most needed and recognizes areas in which improvements already are under way. Finally, it notes the distinctive challenges and opportunities presented by patients with multiple chronic conditions and dementia. The report can be accessed at http://www.dartmouthatlas.org/downloads/reports/Our_Parents_Ourselves_021716.pdf.

Geography Matters When Students Decide Where To Go To College

CLOSING THE INFORMATION GAP BETWEEN PATIENTS AND PROVIDERS

An item in the *Quick Stat* section of page six of this issue of the newsletter describes the positive impact of engaging patients through “Open Notes.” The study upon which this information was obtained appeared online on February 11, 2016 in the *Journal of the American Informatics Association*. The lead author was John Mafi. More details about this investigation are as follows:

Fostering active and constructive patient engagement is central to many efforts designed to improve the quality of healthcare. Yet, many factors hinder patients from taking charge of their health and healthcare, and among them is suboptimal recall and learning associated with a clinical encounter. For example, patients surveyed immediately after visiting their doctors forgot between 40 and 80% of the medical information provided by the doctor. Apart from medical encounters, allied health professionals also often impart significant information to patients regarding what they should be doing at home upon leaving the clinical setting. It is likely that patient recall in these situations may be no better than it is when treated by physicians.

Partly intended to improve patient engagement and patient–doctor communication, Meaningful Use legislation has provided billions of dollars to incentivize the use of electronic health records and online patient portals, including communication tools such as after-visit summaries. Nevertheless, these summaries may prove to be sparse. Moreover, they have not necessarily led to improved patient recall of content or satisfaction with the information provided.

In 2010, with the goal of improving communication and patient engagement, 105 primary care physicians at Beth Israel Deaconess Medical Center in Boston, MA; Geisinger Health System in Danville, PA; and Harborview Medical Center in Seattle, WA volunteered to invite 19,371 of their patients registered on portals to review their signed visit notes and to do so through individual emailed alerts. Initial findings of the project, called the *OpenNotes Trial*, demonstrated considerable patient enthusiasm, improved recall of the medical plan, self-reported clinical benefits, and little impact on primary care physician workflow.

Since publication, many providers have moved to offer fully transparent records to their patients. In 2015, more than five million Americans have ready access to their clinicians’ notes. While the original trial demonstrated substantial initial enthusiasm among patients, however, whether interest in viewing notes persists beyond the first visit or beyond the start of the trial was not known.

Another consideration to take into account is the age of patients and their caregivers. According to a new Infographic developed by the Population Reference Bureau, 10% of patients 65 years-of-age and older have dementia. Among their caregivers at home, 25% are spouses who provide an average of 55 hours of care each week (three or more basic personal care activities, such as dressing, eating, and using the bathroom), which is more than twice the amount of care needed for individuals in that age group who do not have dementia.

Demography in many respects is destiny. Not only is the population at large adding large numbers to the category of the aged, the health workforce itself is aging. Some older health personnel are faced with the dual burden of providing care to patients both in the employment setting and in their own homes. For example, daughters represent 39% of the care furnished at home to parents with dementia. Given that many allied health professions have high proportions of females, these individuals can continue to expect to be called upon to deliver a large portion of health and health-related social services.