CODES DETERMINE HEALTH CONSEQUENCES

The Human Genome Project resulted in the successful unraveling of many essential mysteries associated with the genetic code. An emphasis on personalized medicine that is being pursued at the National Institutes of Health holds great promise for improving treatment of patients. Genomic sequencing can shed light on underlying genetic etiology, making it possible to discover novel variants that point toward accurate diagnoses and perhaps even more effective treatments.

For many individuals in the United States, however, a totally different kind of code may have greater salience regarding their health status. That particular entity is known as the Zip Code. Where societal members live, learn, work, earn a living, and participate in recreation affects to a great extent how long and how well they survive. What constitutes health includes the effects of daily existence. Key factors, such as family stability, how children are raised, the kinds of food eaten, the amount of physical activity performed, the extent to which risky behaviors involving harmful substances like smoking are engaged in, and the quality of residential neighborhoods all exert their influence on health outcomes.

Members of disadvantaged racial and ethnic groups are more likely to live in poor locales. The characteristics of such places, such as limited access to nutritious food; living near toxic wastes, abandoned or deteriorating factories; freeway noise and fumes; and exposure to crime and violence and other hazards increase the likelihood of serious health problems occurring. Unfortunately, factors that increase illness or risk of injury are more common in the daily lives of the nation’s poor and minority families. As a result, living in health-damaging and threatening situations often means that individuals and their families do not have healthy choices they can afford to make.

The presence of schools that are of low quality in a given geographic area and the high costs of obtaining a post-secondary education are conditions that contribute to deficiencies in literacy and numeracy. Many patients fail to acknowledge that they are at a poor reading level, and what sometimes may happen is that providers either do not ascertain that a satisfactory ability to read exists on the part of patients or they feel uncomfortable becoming involved in such discussions. Another complicating factor is that English is a second language for many patients, which can result in problems of non-compliance.

Thus, where an individual lives has diverse impacts on different Zip Code areas from the standpoint of: poverty, marginality/absence of suitable employment, insufficient income, availability of health insurance, pre- and post-natal care, and access to health services. Citing just one example, 36% of counties in the U.S. are further than 50 miles from the nearest gynecologic oncologist, which means that thousands of women with gynecologic cancers may experience a significant geographic barrier to access high-quality care for malignancies.
As an association striving to be a leading interprofessional voice for better health and healthcare, I believe that we have much to learn from our colleagues, collaborators, partners and friends. Therefore, it is a pleasure to start off 2016 with a format intended to include thoughts and commentary from invited guests throughout the year.

The first invited guest, Danielle Ripich, is no stranger to allied health or ASAHP. She served on the ASAHP Executive Board, 2002-05 contributing to our work in health education policy and governmental relations, was named an ASAHP Fellow, and many will remember her as our invited speaker for the Deans’ Memorial Lecture featured at the 2011 ASAHP spring meeting. Dr. Ripich currently serves as the President of the University of New England (http://www.une.edu/president/presidential-profile). She speaks nationally about topics in leadership, higher education and allied health and I have asked her to reflect on what she sees as some of the future needs in allied health education and practice.

Dr. Ripich: I was pleased to be asked to share with you my thoughts on the future of higher education and how it might affect education in the health professions. I am in my 10th year as a president of a private health sciences university that has the only medical school and dental school in the state. We also have a college of health professions that includes social work and nursing and a robust online college with graduate programs in public health, social work and health informatics. My previous position was as dean in a public academic medical center and so I feel I bring a broad perspective as we consider these questions.

I could discuss the megatrend of the digital shift that is occurring in society in general, but I am choosing to look at three specific influences directly affecting our work in the coming decade. The first is the shifting demographics, the second, the changing faculty model and finally, the coming diversity in educational models. Each brings its own set of unique challenges for us to consider. First, our patients and faculty are all rapidly aging. This means we need to adjust curricula to reflect the aging caseloads our graduates will encounter in their careers. Also, we will face challenges in securing faculty, chairs and deans to replace our current ranks. The baby boom is moving into a new phase of life that will create dramatic turnover and impact health professions across the board.

Next, as our faculty retire, universities are not replacing tenure track lines. In 1969 nearly 80% of faculty were tenured or on a tenure track. Fast-forward to 2009 and that number is just over 20%, almost a complete reversal. This trend is predicted to continue, coming to rest, with 10% to 15% of faculty in tenured positions. The magnitude of this shift will be important as we shape the American university of the future. We are likely to be the last generation to enjoy tenure as an expectation. Finally, I feel strongly that, in addition to traditional online programs, Competency Based Education (CBE) for badges, certificates and even degrees will become an important factor in our graduate education programs. We are well positioned to take advantage of this “new” model given our tradition of requiring demonstrated competencies before granting clinical licenses.

We understand self-directed learning that is guided and assessed by faculty (often faculty different from those who designed the competency). In 2015 UNE was awarded a Bill and Melinda Gates Foundation Grant that supported the development of our first and gained regionally (NEASC) accredited CBE program. We launched our program in Health Informatics this month and I was struck by how much we had followed the guidelines that many of our health professions already use for our clinical programs. We need to continue to look for ways to provide access, to keep costs for students contained and to creatively educate the next generation. This may mean new models for adult learners. It is an exciting time for higher education and we can be leaders in many ways as we use our strengths to keep our programs engaged in these challenges and opportunities. I would like to communicate with any of my colleagues interested in further discussions. I truly miss my ASAHP friends and our lively talks. I wish you all the best as you go about educating the health care work force for the future. Danielle
CONGRESS AVOIDS A SHUTDOWN

Congress was successful in preventing a shutdown in 2015 by passing a $1.1 trillion Fiscal Year 2016 omnibus spending bill and tax extenders package in December. The tax legislation includes $680 billion in permanent and short-term extensions of tax breaks for businesses and individuals, including the research and experimentation tax credit. The spending bill adds $5.4 billion to the U.S. Department of Health and Human Services (HHS) funding, including an additional $2 billion for medical research at the National Institutes of Health (NIH).

The additional research funds are targeted toward research on Alzheimer’s disease, the brain, antibiotics, and precision medicine. Funding for the Centers for Disease Control and Prevention (CDC) increased $300 million, the Food and Drug Administration (FDA) was provided an additional $132 million above current spending levels, and the amount made available for veterans’ health increased by $6.4 billion.

As mentioned on the following page of this newsletter, the imposition of the so-called “Cadillac Tax” was delayed for two years, along with a two-year suspension of the medical device excise tax, and a one-year suspension of the annual Health Insurance Tax. The Congressional Budget Office (CBO) estimates that the spending bill will increase the deficit by more than $57 billion over 10 years.

One item left unfinished that is deemed of great importance by many legislators is a bipartisan effort to overhaul the drug approval process at the FDA and revitalize research at the NIH. Toward that end, the House version of a medical innovation bill, the 21st Century Cures Act (H.R. 6), passed that chamber in July 2015 by a vote of 344 to 77. The Senate has not achieved as much action regarding this legislation. Instead, Senator Lamar Alexander (R-TN), Chairman of the Senate Health, Education, Labor and Pensions (HELP) Committee announced that his committee will not be working on a Senate version of the House’s 21st Century Cures Act. Instead, the plan is to vote separately on different medical innovation bills. Markups to consider health legislation are scheduled for February 9, March 9, and April 6, 2016.

If the House version ever is enacted into law, 21st Century Cures will be paid for through mandatory funding instead of discretionary funding, which means that funds will not be subject to spending caps and will not have to be considered each year during the appropriations process. The bill authorizes NIH to establish a medical innovation prize for breakthrough science and another amendment to support young women and minority scientists.

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

Legislation Passed To Repeal The Affordable Care Act

The second session of the 114th Congress began in January 2016 with sending reconciliation legislation to President Obama to repeal most of the Affordable Care Act. The House Republicans’ version was expanded upon by the Senate. The legislation was passed through the fast-track budget tool known as reconciliation, which allowed the bill to pass the Senate with a simple majority rather than the 60-vote threshold that is required to overcome a filibuster. It would have eliminated federal funding for Planned Parenthood for one year and boosted funding for community health centers. Some legislative provisions would have undone Medicaid expansion, eliminated federal subsidies to help purchase health insurance, eliminate both individual and employer mandates, and delayed many of the law’s taxes, including the medical device tax and the “Cadillac Tax.” It came as no surprise when President Obama vetoed this legislation on January 8. He signaled his intention to do so by issuing a Statement of Administration Policy (SAP) on December 2, indicating strong opposition because the repeal would result in millions of individuals remaining uninsured or losing the insurance they currently possess.

Democrats used the same mechanism of reconciliation to help enact the health care law in 2010 after they lost their 60-vote Senate majority. Among a wide range of key provisions, the Affordable Care Act established subsidies for low- and middle-income Americans to help purchase health coverage through new insurance exchanges and it expanded the Medicaid program.

Health Exchange Enrollment Estimate Reduced

The Congressional Budget Office (CBO) on January 25, 2016 indicated that an estimate of how many individuals would obtain health insurance coverage through the exchanges or what also are called public marketplaces this year is being reduced. An original projection of 21 million of them has been changed to 13 million. Also, instead of an estimated 15 million policyholders receiving subsidies, 11 million are expected to do so. These events are occurring in the third enrollment season, which is the last one to occur during the Obama Administration.

The report provides an indication of the challenges involved in further reducing the size of the uninsured portion of the population in the U.S. Meanwhile, the cost of subsidies is expected to increase $18 billion in 2016, reaching a total of $56 billion, and perhaps even doubling that amount within the decade.

Special Enrollment Periods

Generally, enrollment in the marketplaces is scheduled to occur in the period November to January, but there are exceptions made in the form of Special Enrollment Periods (SEPs). Examples would be when divorces occur or when individuals lose their jobs. In January 2016, the Centers for Medicare and Medicaid Services (CMS) indicated that it will eliminate certain SEPs and increase enforcement of the rules around them by clarifying eligibility requirements and increasing enforcement to prevent fraud. Executives of insurance companies have expressed concern about the many qualifying life events that can result in added enrollment.

Currently, premium costs are skewed in a way that younger, healthier beneficiaries pay higher amounts than beneficiaries who are older and sicker. If younger individuals do not enroll in sufficient numbers, then insurance company expenditures can exceed premium revenue. A related issue is that some of these younger enrollees will do so only after they develop health problems, which can add to greater costs assumed by the insurance companies. For these kinds of reasons, UnitedHealth Group, the largest insurance company, has indicated that it may withdraw from the exchanges.
ACCREDITATION OF HIGHER EDUCATION INSTITUTIONS

Accreditation is an important component of events in the higher education domain. Several decades ago, it was possible for students to attend college and be able to cover tuition costs through such means as bagging groceries in a supermarket on weekends and having a summer job. Unfortunately, those days appear to be gone forever. Even in families where both parents have good paying jobs, the hefty nature of educational costs has produced a situation that calls for assuming loans to offset the financial burden.

Role Of The Federal Government
As a means of enabling students to be able to afford a college education, the federal government has created several forms of financial support involving huge sums of money. Consequently, it views its role as making certain that the accreditation process is transparent enough to provide an assurance that academic programs are of sufficient quality and effectiveness that they lead to positive student outcomes. A metric that often is mentioned is that upon graduation, students should be prepared to obtain decent paying jobs and it should be up to academic institutions to show how such an outcome is achieved.

Critics of any more robust role complain that in carrying out its responsibilities, the federal government generates regulations that not only are voluminous, they also can be too ambiguous. In such cases, complying with these rules not only can have a negative impact on college costs, but burdensome regulations even may interfere with student access to obtaining a higher education.

Another complaint stems from a belief that the federal government has a tendency to view accreditation agencies as a regulatory extension of the U.S. Department of Education and has significantly increased the responsibilities of academic administrators as a condition of approving higher education institutions. Instead, opponents emphasize that accreditors should be directing their energies to focus on student learning and educational quality while letting the Department focus on enforcing Title IV student financial aid program eligibility requirements.

Role Of Employers
Apart from parents, students, accreditation organizations, and governmental agencies, another group making its sentiments known is in the realm of the employment sector. The U.S. Chamber of Commerce Foundation and USA Funds want employers to have a stronger voice in the accreditation process, perhaps even to the extent of creating an alternative, complementary form of quality assurance that would be employer-driven. A report, “Changing the Debate on Quality Assurance in Higher Education,” by the two organizations that was issued on January 27, 2016 contains that central idea based on the rationale of a gap in skills that results in millions of jobs going unfilled because workers lack proper training.

According to the report, companies have difficulty growing and competing in today’s economy because of a disconnect between the business community and higher education. A survey by Gallup is cited, showing that only 11% of business leaders perceive college graduates to be ready for work, whereas 96% of chief academic officers in the nation’s colleges believe students are adequately prepared to start their careers. Moreover, students themselves perceive this disconnect, with only 35% feeling prepared to enter the world of work. This problematic situation is compounded due to the increasing number of nontraditional students who are now entering higher education to improve their career opportunities. With higher education being the chief source of talent for the business community, it is considered of paramount importance to address this disconnect.

The health part of the employment sector is not immune to similar criticism. Graduates of health professions education programs are called upon to function in a more patient-centered way and demonstrate an ability to work more effectively in teams that include members of other health professions.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Out-Of Pocket Health Care Expenses
According to the Employee Benefit Research Institute (EBRI), the average per-person out-of-pocket spending for households ages 65 and above during a two-year period on doctor visits, dentist visits, and prescription drugs (referred to collectively as recurring health care services) is roughly $2,500 for both single and couple households. This amount does not change with age. Large differences exist in non-recurring health care spending (which includes overnight hospital stays, outpatient surgery, home health care, nursing home stays, and other services) between older singles and older couples, and these differences increase with age. For those 85 and above, singles and couples on average spent $13,355 and $8,530, respectively, on these services during the two-year period of a study. Some of the largest differences in non-recurring health care spending between older singles and older couples are in home health care and nursing home expenses, suggesting that couples benefit from their spouses or partners acting as their caregivers.

Burden Of Medical Debt
Results announced in January 2016 of a Kaiser Family Foundation/New York Times Medical Bills Survey show that 26% of adults age 18-64 had problems paying medical bills over the last 12 months. While the uninsured (53%) had more difficulty than other groups, having insurance did not protect everyone from financial problems with medical bills. Many individuals with employer-sponsored insurance (19%), Medicaid (18%), or direct purchase (22%) also reported having trouble paying medical bills in the last year. Having a high deductible also was a strong predictor of trouble. Individuals (26%) with private insurance and a high deductible had trouble, compared with only 15% with private insurance and a low deductible.

HEALTH TECHNOLOGY CORNER

Next Generation Of Medicinal Plants
The issue of the journal The Lancet for 16-22 January 2016 indicates that centuries after their appearance inside monastic walls, physic gardens spread to university campuses in Medieval and Renaissance Europe to assist the education of physicians and apothecaries. Today, physic gardens seldom exist on hospital campuses. Yet, medicinal plants continue to have a central role in caring for patients. Just as in the Middle Ages and Renaissance, historical forces are now refiguring the role of gardens in modern medicine at a time when countries face the growing burden of chronic diseases. Some hospitals are using their soil not only for the cultivation of medicinal plants, but also for community gardens—pieces of land collectively used for food production. A national study recently identified 110 community gardens affiliated with hospitals in the USA. Some hospitals incorporate gardening directly into patients’ care. For instance, occupational therapists working alongside patients with dementia, stroke, or traumatic brain injury have developed garden-based exercises to support skill-building, activities of daily living, and adaptive strategies, while also taking advantage of the sensory and non-institutional aspects of green space for psychosocial benefit. An example of such a place is a 127-plot community garden on the campus of Penn State Hershey Medical Center in Hershey, PA.

Design Of Small Autonomous Drones And Ground Robots To Perform Simple Household Tasks
Researchers at the University of Illinois recently obtained a grant from the National Science Foundation to explore strategies to design small autonomous drones and ground robots to perform simple household tasks. It is believed that in the next several years, such devices may be able to assist older individuals who have chronic conditions and want to stay in their homes as long as possible. Some of the tasks the team is envisioning include retrieving medication from another room, household cleaning, and other tasks that could reduce the risk of falls in older adults who live alone.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Top Regulatory Trends For 2016 In Life Sciences & Health Care

As Congress continues to consider health care legislation amid election-year politics and the Affordable Care Act remains a central point of debate, the regulatory events that lie ahead in 2016 and beyond will mark some of the most significant changes to the US health care industry. The life sciences and health care sectors face a year full of activity, with the prospects of the election year spotlight once again being directed to the health care marketplace. As a way of anticipating, accommodating, and being ahead of the evolving regulatory landscape, a report from Deloitte examines the challenges and opportunities regarding the following six key areas: ACA implementation, excise tax on high-cost employer-sponsored coverage, Medicare payment reform, Medicaid managed care, 340B drug pricing program, and life sciences regulatory topics. The report can be accessed at http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-reg-outlooks-lshc-2016.pdf.

The Role Of Public-Private Partnerships In Strengthening Health Systems

On June 25–26, 2015, the National Academies of Sciences, Engineering, and Medicine Forum on Public–Private Partnerships for Global Health and Safety (PPP Forum) held a workshop on the role of public–private partnerships (PPPs) in strengthening health systems. The workshop brought together representatives from the public and private sectors to: examine a range of incentives, innovations, and opportunities for relevant sectors and stakeholders in strengthening health systems through partnerships; explore lessons learned from previous and ongoing efforts with the goal of illuminating how to improve performance and outcomes going forward; and discuss measuring the value and outcomes of investments and documenting success in partnerships focused on strengthening health systems. A workshop report provides a summary account of the presentations given at the event. The report can be accessed at http://www.nap.edu/catalog/21861/the-role-of-public-private-partnerships-in-health-systems-strengthening.

Online Resource For Exploring Health Care Around The World

Across the globe, health care policymakers face mounting pressure to lower costs while improving the quality and safety of care. The U.S. can learn a lot by examining other health systems, their performance in relation to this country, and their health care delivery and payment innovations. A new website profiles the health care systems of 18 countries, providing information that includes: how care is delivered and financed; what’s being done to control costs; and what new reforms and innovations have been introduced. The site draws on the newly updated International Profiles of Health Care Systems, written by leading experts in each country and edited by researchers from the London School of Economics and Political Science and The Commonwealth Fund. Users also can view data visualizations from The Commonwealth Fund’s most recent international health policy survey. The website can be accessed at http://international.commonwealthfund.org/.

Changing The Pell Grant Program To Assist More Students

A Fact Sheet from the U.S. Department of Education describes two new Pell Grant Program proposals that will help students to accelerate progress towards their degrees by attending school year-round and encourage them to take more credits per term, increasing their likelihood of on-time completion. The Fact Sheet can be accessed at http://www.ed.gov/news/press-releases/fact-sheet-helping-more-americans-complete-college-new-proposals-success.
PLANNING TO MEET HEALTH CARE WORKFORCE NEEDS

The U.S. Government Accountability Office (GAO) released a report on January 11, 2016 that examines (1) HHS’s planning efforts for ensuring an adequate supply and distribution of the nation's health care workforce and (2) the extent to which individual HHS health care workforce programs contribute to meeting national needs. GAO recommends that HHS develop a comprehensive and coordinated planning approach that includes performance measures, identifies any gaps between its workforce programs and national needs, and identifies actions to close these gaps.

In fiscal year 2014, Health and Human Services (HHS) obligated about $14 billion to 72 health care workforce education, training, and payment programs administered primarily through five of its agencies. HRSA manages the most programs related to health care workforce development, while CMS, ACF, IHS, and SAMHSA also oversee other such programs. HRSA managed 49 of the 72 HHS workforce programs in fiscal year 2014. These programs generally provide financial assistance to students and institutions—in the form of scholarships, loan repayments, or grants—to encourage students to train and work in needed professions and regions. These programs accounted for about 8% of HHS’s $14 billion in obligations for workforce development programs.

In contrast, CMS managed three graduate medical education (GME) payment programs that together accounted for about 89% of this funding. These payments reimburse hospitals for the cost of training medical residents and are calculated, in part, based on the number of residents at the hospital.

HHS OBLIGATIONS FOR HEALTH CARE WORKFORCE PROGRAMS, BY AGENCY, FY 2014

Source: GAO analysis of HHS data. | GAO-16-17

Note: “Health care workforce” includes those professionals who provide direct health care, including, but not limited to, audiologists, chiropractors, dentists, medical assistants, nurses, occupational therapists, optometrists, pharmacists, physical therapists, physicians, physician assistants, podiatrists, psychologists, social workers, and counselors. The Office of the Surgeon General and the Office of Population Affairs collectively operate three additional health care workforce programs, obligating less than $5 million combined in fiscal year 2014.