CAPITALIZING ON PAST LESSONS

Readers of this newsletter who have grown long in the tooth may recall that tuberculosis was not always known for being a relatively minor disease from the standpoint of its morbidity and mortality. As late as the 1950s, sanitariums and TB hospitals continued in operation across the U.S. These custodial institutions have since disappeared into the distant recesses of memory. Yet, there may be some useful lessons to be learned from a discussion of TB that are applicable to future efforts to improve community and individual health status.

World Tuberculosis Day is recognized each year on March 24, commemorating the date in 1882 when Robert Koch announced his discovery of *Mycobacterium tuberculosis*, the bacillus that causes this disease. In 2016, a total of 9,287 new TB cases occurred in the United States (incidence of 2.9 cases per 100,000 persons), representing the lowest number of cases recorded. Despite much progress, data suggest that current strategies will not be sufficient to reach the goal of elimination of the disease in this century.

As revealed in a paper released in March 2017 from the National Bureau of Economic Research, 194 out of every 100,000 Americans in 1900 died of tuberculosis (TB), making it the 2nd leading cause of death, trailing only pneumonia/influenza. Although an effective treatment would not be introduced until after World War II, the TB mortality rate fell dramatically over the next three decades. By 1920, it had declined to 113 per 100,000 persons and by 1930, it had dropped to 71 per 100,000 persons. What factors accounted for this steady decline?

Better living conditions; herd immunity due to natural selection; reduced virulence; improved nutrition; isolating patients in sanatoriums and TB hospitals; open-air camps; prohibitions on spitting and the use of common drinking cups; and requirements that the premises of deceased TB patients be disinfected have been credited as effective measures. Current analysis, however, indicates that with the exception of requiring cases to be reported to local health officials (producing a 6% reduction) and the opening of state-run sanatoriums (producing a 4% reduction), these other approaches had no discernable impact on pulmonary TB mortality.

An examination of the top 10 causes of death in the U.S. shows that with the exception of influenza and pneumonia, infectious diseases have been replaced by conditions where behavioral elements play a significant role, such as heart disease, cancer, stroke, accidents, diabetes, and suicide. Allowing a sense of complacency about the dangers of infectious agents still could result in serious consequences. Equally important is the ability to craft proper effective responses to disease outbreaks. In 2014, a single death and a tiny handful of isolated cases attributed to Ebola produced large-scale panic in the U.S., including calls in the media for the Director of the CDC to be fired. Some politicians demanded travel bans while children who had traveled to Africa were prevented from attending school. Clear thinking was replaced by hysteria, which also is not an especially useful reaction.
This month’s invited guest sharing some thoughts is ASAHP Executive Director John Colbert regarding: “The debate over the future role of the federal government – what does it mean to ASAHP?”

The new Administration has shaken the Washington establishment to its core, leading concurrent efforts that may fundamentally reshape the size and scope of domestic programming moving forward by attempting to reduce the federal footprint, repeal and replace the Affordable Care Act, and broadly curtail government regulations. All three of these thematic efforts also have an impact on allied health education and health care more generally. The Administration recently released its FY 2018 budget overview requesting $54 billion in cuts to domestic programs – just over 10% overall. A detailed budget proposal will be submitted in May.

For programs of importance to ASAHP, the proposed cuts run even deeper, a $12.6 billion (16%) cut to the Department of Health and Human Services and a $9 billion (13%) cut to the Department of Education. While not all of these cuts have been spelled out, the budget does specifically propose $403 million reduction to HRSA’s health professions and nursing programming, along with a $5.6 billion cut to the National Institutes for Health (NIH), which would reduce future medical research grant making and erase additional funding secured through the passage of the 21st Century Cures legislation last year. It is important to understand that the Administration’s proposal to make cuts does not mean they will be enacted -- it is merely the first step in a yearlong funding process. Key Republican Members of Congress – including the Chairman of the House Appropriations Committee in charge of the annual funding process, have expressed great dismay at the Administration’s request to cut $54 billion from domestic programs, pointing out that these programs are already funded at the lowest levels in nearly two decades and declaring if the Administration wants to propose budget cuts, find them elsewhere.

The old acronym still holds true “the President proposes and the Congress disposes” when it comes to budget proposals – but the Administration’s budget request is a reflection of its priorities, which will likely be debated many times during the next four years. In the short term, major domestic funding reductions are unlikely, as Democrats are united against major domestic cuts and the support of eight Democratic Senators (along with every Republican Senator) will be required to garner the 60 votes necessary to approve funding bills on the Senate floor. Bipartisanship is an essential component in the annual funding process and if consensus cannot be found, we should anticipate more long-term Continuing Resolutions (CRs) to keep the government funded at close to current funding levels for the foreseeable future. Along with the debate over the shape and scope of federal funding, the first two months have been marked by a concerted effort to reduce the number of regulations promulgated by the Obama Administration through both delaying ongoing regulatory efforts, as well as eliminating final rules through the Congressional Review Act. While most of the Department of Education regulations addressed to this point have been focused on elementary and secondary education, Secretary DeVos has also chosen to put a hold on rulemaking that would clamp down on for-profit institutions under the “gainful employment” rule and is also expected to put a hold on additional accountability-related rulemaking. This shift in direction is reflective of the different views on for-profit education between the two political parties, as Democrats clamped down on for-profit education under the Obama Administration and Republicans are working quickly to reverse regulatory restrictions in this arena.

The most contentious area in which the new Administration and Republican majorities in Congress have been debating is the repeal and replacement of the Affordable Care Act, a high campaign priority for both the Administration and Republicans in Congress, which voted dozens of times in the House to repeal Obamacare, only to have their bills repelled by the Administration. This year, a procedural mechanism called “budget reconciliation” that allows passage on the Senate floor with a simple 50 vote majority solely for cuts to mandatory programs, has been utilized by the Republican leadership to develop a replacement for Obamacare called the American Health Care Act (AHCA).

While there was unity in opposition to Obamacare under the previous Administration, now that Republicans lead both the Executive Branch and both chambers in Congress, crafting a replacement bill that secures the support of all elements of the Republican party has proven elusive and underlies the challenges of governing during this volatile moment in history. We will have a better sense over the next few weeks, if not months, whether health care reform can actually move towards enactment, as well as its implications for allied health professions moving forward.
FEDERAL “SKINNY BUDGET” NOT POPULAR

As noted in the Guest Commentary by ASAHP Executive Director John Colbert on page two of this issue of the newsletter, President Donald Trump on March 16, 2017 released the first draft of the national budget for fiscal year (FY) 2018, outlining his Administration’s priorities. Documents of this nature often are referred to as “skinny budgets” because they usually do not itemize line-by-line appropriations. Other missing pieces are funding proposals for non-discretionary entitlement programs, such as Medicare and Medicaid, representing large amounts of money.

Given the magnitude of the proposed spending reductions in several highly popular categories, e.g., the National Institutes of Health (NIH), it comes as no big surprise that the budget failed to generate enthusiasm among many members of Congress. The usual reaction there is to pronounce it dead on arrival.

Nevertheless, a budget proposal that includes spending reductions is in accord with concerns about a steadily growing overall federal deficit. Annual interest payments on that debt command rather sizable outlays of money. Concerns that some programs are plagued by fraud and abuse, coupled with impressions that not all of them are proving to be as effective as originally intended are additional factors that furnish a rationale for seeking to undertake some financial trimming.

As is often the case, however, each category of expenditure has one or more interest groups that will labor assiduously to protect assets that are directed at endeavors that they favor. Elected legislators have to be especially mindful of special interest constituencies of voters who can play a major role in determining who is able to remain in public office through choices made in voting booths and in the resources these individuals and groups can provide that are necessary to conducting effective political campaigns.

The domain of appropriations will continue to be a key aspect of legislative deliberations in 2017. Action in that arena is expected to be accompanied by a Republican-led initiative to lower taxes. Although GOP attempts to reform the Affordable Care Act screeched to a halt on March 24 this year, it is uncertain whether additional efforts in that direction will be launched in 2017.

Meanwhile, more than 1,500 bills have been introduced in the House so far this year and more than 600 in the Senate. A great many pertain to health (e.g., allow physical therapists to participate in the National Health Service Corps Loan Repayment Program and amend some Medicare provisions). Clearly, legislators will have plenty of work to keep themselves occupied.

2017 ASSOCIATION CALENDAR OF EVENTS

June 2017—Spring Issue of Journal of Allied Health Distributed

August 2017—Scholarship of Excellence Recipients Announced

September 2017—ASAHP Election Results Announced

October 18-20, 2017—ASAHP Annual Conference in San Antonio, TX

Note: Efforts are underway to identify future conference locations and dates.
AFFORDABLE CARE ACT DEVELOPMENTS

Seven years ago this month, Democrats were successful in having the Affordable Care Act become law. Within their party ranks, some members of Congress were dissatisfied that this major piece of health reform legislation failed to create a single payer system. Their colleagues on the other side of the aisle had a different set of complaints, which they evidenced by not having a single member of their party vote in favor of this overhaul of health care in the U.S.

The health sphere constitutes approximately 20% of the world’s largest economy. Any large scale attempt to make changes in health care will have consequences that not only have the prospect of affecting morbidity and mortality, but also may influence taxation policy, overall job creation, the health workforce, immigration, and key economic components, such as the hospital and health insurance industries.

The collapse on March 24, 2017 of a Republican effort to repeal and replace the Affordable Care Act with a new American Health Care Act (AHCA) was characterized by many similar factors. The inability to produce a new law that modifies taxes related to health care means that an upcoming effort to lower taxes overall may be compromised. Lobbying groups representing different health professions, e.g., physicians, were opposed to the AHCA. Also, a failure to produce a House bill that would repeal the Affordable Care Act in its entirety provided sufficient reason for some of the more conservative Republicans to stay on the sidelines, thereby denying their party the number of votes required to achieve victory.

Most changes over the decades to reform health care have occurred incrementally. Both the Affordable Care Act and the American Health Care Act have demonstrated rather convincingly that in order for massive alterations to occur effectively, it will be necessary to have significant endorsement by sufficient numbers of Democrats and Republicans. For the nonce, the Affordable Care Act lives on. How long it will remain in its present form continues to be an unanswered question.

Health Insurance Open Enrollment Results
An open enrollment report from the U.S. Department of Health & Human Services (HHS) on March 15, 2017 shows that approximately 12.2 million individuals signed up for coverage through the public health insurance exchanges in 2017. That number is roughly 500,000 fewer than the 12.7 million persons who enrolled last year. The final report covers the 39 states that used HealthCare.gov and the 12 states that run their own program. Some other findings are: (1) approximately 8.4 million beneficiaries re-enrolled from 2016, while 3.8 million individuals were new to the marketplaces; (2) nearly 10.1 million persons (84%) qualified for advanced premium tax credits and seven million others (58%) were eligible for cost-sharing reductions; and approximately 74% percent of those in HealthCare.gov states selected a silver plan in 2017 compared to 71% in 2016. The 2017 open enrollment period ran from November 1, 2016 to January 31, 2017.

Uncompensated Care For Medicaid And Uninsured Patients
The Medicaid and CHIP Payment and Access Commission (MACPAC) on March 15, 2015 released a new analysis showing that total hospital uncompensated care for Medicaid and uninsured patients fell by about $4.6 billion (9.3%) between 2013 and 2014, with the largest declines in states that expanded Medicaid. The same study, however, found that although uncompensated care fell in all but three states, hospitals serving the greatest share of low-income patients would experience negative margins if not for federal disproportionate share hospital (DSH) payments. The findings are part of an analysis of DSH payments that MACPAC is required to submit yearly as part of its March Report to Congress on Medicaid and CHIP. The 2017 report analyzes several approaches to better target DSH payments to hospitals with high Medicaid and uninsured caseloads, including raising the minimum threshold to receive such payments from a 1% Medicaid utilization rate to a higher threshold. The report also examines how states monitor Medicaid beneficiaries’ access to care and reprises MACPAC’s nine recommendations, issued in January, to extend federal State Children’s Health Insurance Program (CHIP) funding and strengthen children’s health coverage.
DEVELOPMENTS IN HIGHER EDUCATION

Reauthorization of the Higher Education Act is not a topic receiving much attention lately. An exception is a hearing that was held on Capitol Hill on March 21, 2017 by the House Subcommittee on Higher Education and Workforce Development, which is chaired by Rep. Brett Guthrie (R-KY). The focus was on how to streamline and simplify federal student aid. His position is that over the years, the federal student aid system has become too complex. Students and their families are forced to navigate six different types of federal student loans, nine different repayment plans, eight different forgiveness programs, and 32 deferment and forbearance options, each with its own rules and requirements. He cited the need to eliminate this complexity and the confusion students face. Comments made by three witnesses at the hearing are as follows:

Testimony Of JoEllen Soucier, Executive Director Of Financial Aid, Houston Community College System
She stated that paying for college is inherently complicated. Challenges that students face with the current financial aid system can be categorized into four key areas: the federal application process, consumer information, student aid programs, and student loan repayment. One of the most difficult parts of the application process for students isn’t necessarily completing the federal application form, but all of the extra work students must do to verify the accuracy their reported data.

Testimony Of Kristin D. Conklin, Founding Partner, HDM Strategists
She provided information about: recommendations for simplifying further the needs analysis; application and renewal processes for federal student aid; recommendations for consolidating the multiple federal grant and loan programs into a single one-grant, one-loan system, with on-time completion incentives and options for projected savings; and public opinion research for these simplification proposals. HCM has led a panel offering a set of options to place student outcomes at the center of federal student aid programs.

Testimony Of Matthew M. Chingos, Senior Fellow, The Urban Institute
He said that the prevailing media narrative of a broad-based student loan crisis is problematic because it leads to the wrong policy solutions by focusing on all borrowers. Individuals most likely to struggle are those who never complete a degree. The fact that the typical borrower is in a reasonably strong financial position does not mean that all is well with student lending in the United States. In fact, there are five crises in student lending that are too often overshadowed by the exaggerated media narrative.

Proposed FY 2018 Administration Budget For The Department of Education
According to President Donald Trump’s proposed budget for fiscal year 2018, discretionary funding for the Department of Education would be $59 billion, a $9 billion or 13% reduction below the 2017 annualized continuing resolution (CR) level. Among other aims, the Department would focus on streamlining and simplifying funding for college, while continuing to help make college education more affordable by:

- Eliminating the Federal Supplemental Educational Opportunity Grant program, a less well-targeted way to deliver need-based aid than the Pell Grant program, to reduce complexity in financial student aid and save $732 million from the 2017 annualized CR level.
- Safeguarding the Pell Grant program by level funding the discretionary appropriation while proposing a cancellation of $3.9 billion from unobligated carryover funding, leaving the Pell program on sound footing for the next decade.
- Protecting support for Historically Black Colleges and Universities and Minority-Serving Institutions, which provide opportunities for communities that often are underserved, maintaining $492 million in funding for programs that serve high percentages of minority students.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Decline In Infant Mortality Rate
Infant mortality is considered a basic measure of public health for countries around the world. Over the past decade, the overall rate in the U.S. declined 15% from 6.86 infant deaths per 1,000 live births in 2005 to 5.82 in 2014. It dropped for all major racial and ethnic groups except American Indians/Alaska Natives, according to new data from the Centers for Disease Control and Prevention (CDC). Rates declined 21% among Asian/Pacific Islander women, 20% among black women, 15% among white women, and 11% among Hispanic women. Among the leading causes of infant death, rates declined 29% for sudden infant death syndrome, 11% for congenital malformations, 8% for short gestation/low birthweight, and 7% for maternal complications. The mortality rate for unintentional injuries increased 11% over the period. In 2014, black and American Indian/Alaska Native women had the highest infant mortality rates at 10.93 and 7.59 per 1,000 live births, respectively.

Mortality And Costs Stemming From Hospital-Acquired Conditions
According to the Agency for Healthcare Research and Quality (AHRQ), estimates for 2015 show a 21% decline in hospital-acquired conditions (HACs) since 2010. A cumulative total of 3.1 million fewer HACs were experienced by hospital patients over the 5 years (2011, 2012, 2013, 2014, and 2015) relative to the number of HACs that would have occurred if rates had remained steady at the 2010 level. The preliminary 2015 rate is 115 HACs per 1,000 discharges, down from 2013 and 2014, which had held at 121 HACs per 1,000 discharges. It is estimated that nearly 125,000 fewer patients died in the hospital as a result of HACs and that approximately $28 billion in health care costs were saved from 2010 to 2015 due to the reductions in HACs. Compared with the HAC rate in 2010, more than 37,000 fewer patients died from HACs in 2015. The improvement saved about $8.3 billion in 2015.

HEALTH TECHNOLOGY CORNER

Hydraulic Forces In Hearts Same As Hydraulic Brakes in Cars
Researchers at Karolinska Institutet and KTH Royal Institute of Technology in Sweden have contributed to a recent discovery that the heart is filled with the aid of hydraulic forces, the same as those involved in hydraulic brakes in cars. The findings open avenues for completely new approaches to the treatment of heart failure, which is a common condition in which the heart is unable to pump sufficient quantities of blood around the body. Hydraulic forces that help the heart's chambers to fill with blood arise as a natural consequence of the fact that the atrium is smaller than the ventricle. Many patients have disorders of the filling phase, often in combination with an enlarged atrium. If the atrium becomes larger in proportion to the ventricle, it reduces the hydraulic force and thus the heart's ability to be filled with blood. The results were published on March 2, 2017 in the journal Scientific Reports.

Smartphone Diagnosis Of Male Infertility
Current standard methods for diagnosing male infertility can be expensive, labor-intensive, and require testing in a clinical setting. Cultural and social stigma, and lack of access in resource-limited countries, may prevent men from seeking an evaluation. Investigators at Brigham and Women's Hospital in Boston and Massachusetts General Hospital set out to develop a home-based diagnostic test that could be used to measure semen quality using a smartphone-based device. New findings by the team indicating that the smartphone-based semen analyzer can identify abnormal semen samples based on sperm concentration and motility criteria with approximately 98% accuracy as discussed in an article on March 22, 2017 in the journal Science Translational Medicine.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Viewing Post-Acute Care In A New Light

Health care leaders are juggling the demands and opportunities of a transforming market. New entrants are disrupting the status quo and traditional players are reinventing themselves. Payment and care models are changing and organizations are searching for ways to innovate for cost and quality improvement. This last point certainly rings true for post-acute care, as health systems and health plans begin to view this industry segment in a new light—as one that can deliver more value and opportunities to their organization. A good example is the impact on Medicare. More than one in five Medicare patients discharged from a hospital receives post-acute care. To understand the industry’s post-acute care strategies, the Deloitte Center for Health Solutions interviewed 36 executives from 27 organizations, including health systems, health plans, post-acute care companies, and professional associations. Their insights provide a useful roadmap for organizations as they look to boost post-acute care value. The paper can be obtained at file:///C:/Users/Tom/Downloads/us-lshc-post-acute-care-innovation-report.pdf.

Challenges Of And Opportunities For Cellular Therapies In Regenerative Medicine

Regenerative medicine holds the potential to create living, functional cells and tissues that can be used to repair or replace those that have suffered potentially irreparable damage due to disease, age, traumatic injury, or genetic and congenital defects. The field of regenerative medicine is broad and includes research and development components of gene and cell therapies, tissue engineering, and non-biologic constructs. Although regenerative medicine has the potential to improve health and deliver economic benefits, this relatively new field faces challenges to developing policies and procedures to support the development of novel therapies that are both safe and effective. In October 2016, the National Academies of Sciences, Engineering, and Medicine hosted a public workshop with the goal of developing a broad understanding of the opportunities and challenges associated with regenerative medicine cellular therapies and related technologies. Participants explored the state of the science of cell-based regenerative therapies within the larger context of patient care and policy. A publication summarizes the presentations and discussions from the workshop. A copy can be obtained at https://www.nap.edu/read/24671/chapter/1#xix.

Technology Vision 2017

A report from Accenture examines the question, “How will the future unfold?” What is known unequivocally is the digital revolution is here. It’s cascading across every industry, causing widespread enterprise disruption and wholly redefined customer expectations. The report discusses how organizations are forming partnerships with competitors to create entirely new ventures using platform technologies. A company that is weaving itself into the new digital society is CVS Health, which has gone from filling prescriptions to being a provider of affordable basic healthcare services, deeply embedded in their customers’ lives. With the company’s smart watch compatible mobile app, customers can set personalized reminders for taking their medication, snap pictures of their prescriptions to expedite refills, and scan their insurance card so that store clerks are prepared with up-to-date information. Minute Clinics offer a wide range of services, all of which can be booked and paid for online. For patients who can’t make it to a physical location, partnerships with services like Teladoc enable them to obtain care via phone or video chat. The report can be obtained at https://www.accenture.com/t20170206T064234__w__/us-en/_acnmedia/Accenture/next-gen-4/tech-vision-2017/pdf/Accenture-TV17-Full.pdf?la=en.
AMERICA’S HEALTH RANKINGS OF STATES

For almost three decades, America’s Health Rankings produced by the United Health Foundation has provided an analysis of national health on a state-by-state basis by evaluating a historical and comprehensive set of health, environmental, and socioeconomic data to determine national health benchmarks and state rankings. The Rankings employs a unique methodology, developed and annually reviewed and overseen by a Scientific Advisory Committee of leading public health scholars. The data in the report come from well-recognized outside sources such as the Centers for Disease Control and Prevention, American Medical Association, FBI, Dartmouth Atlas Project, U.S. Department of Education, and the Census Bureau.

Hawaii takes the title of the healthiest state in 2016, followed by Massachusetts (second). Connecticut (third) rises three spots this year to re-enter the top five. Minnesota (fourth) and Vermont (fifth) complete the top five. Hawaii has ranked first for five straight years and has been in the top spot eight times since 1990, the most for any state in the history of America’s Health Rankings. It has been in the top six states since the first edition of America’s Health Rankings in 1990. States that ranked numbers six through ten are: New Hampshire, Washington, Utah, New Jersey, and Colorado.

Hawaii also scores far better than other top-five states. It’s strengths include a low prevalence of obesity, a low percentage of individuals without health insurance, and a low rate of preventable hospitalizations. Also, HPV immunization among females aged 13 to 17 years increased 38% from 38.0% to 52.4% in the past year. The prevalence of diabetes decreased 13% from 9.8% to 8.5% of the adult population.

All states have challenges and areas for improvement. For example, Hawaii scores above the national average in the prevalence of excessive drinking and incidence of Salmonella, and below the national average for tetanus-diphtheria-acellular pertussis (Tdap) immunization among adolescents aged 13 to 17 years.

SYNDEMICS MODEL OF HEALTH

Although the term syndemics has not risen to the level of being a common household word, its implications are worthy of discussion. According to a series of articles in the March 4-10 issue of the journal The Lancet, a syndemics model of health focuses on the biosocial complex, which consists of interacting, co-present, or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction. This emergent approach to health conception and clinical practice reconfigures conventional historical understanding of diseases as distinct entities in nature, separate from other diseases and independent of the social contexts in which they are found. Instead, all these factors tend to interact synergistically in various and consequential ways, having a substantial impact on the health of individuals and whole populations. Specifically, a syndemics approach examines why certain diseases cluster (i.e., multiple diseases affecting individuals and groups); the pathways through which they interact biologically in individuals and within populations, and thereby multiply their overall disease burden; and the ways in which social environments, especially conditions of social inequality and injustice, contribute to disease clustering and interaction as well as to vulnerability.

Its framing language has focused specifically on interaction or synergism. The disease burden attributable to health risks in combination exceeds the sum of the disease burden of the health risks when considered separately. Examples draw on the language of interaction, e.g., the risk of hepatocellular carcinoma is greater among individuals with chronic hepatitis C virus infection who also consume alcohol (than among individuals who either have hepatitis C or consume alcohol, and persons who neither have hepatitis C nor consume alcohol).