A well-known bidding is “Don’t just stand there, do something,” which is the exact opposite of the title of this newsletter article, a formulation that could be considered a *façon de parler*, a rhetorical turn of phrase that perhaps should not be taken too literally. Yet, in the realm of health care interventions, there are instances when less care is better than more care and no care might be even more beneficial than less care.

Many patients are in a quandary when it becomes necessary to select a path to follow to improve their health status. Confusing recommendations in the form of dueling guidelines from providers pose one kind of problem. For example, recent clinical practice guidelines from the United States Preventive Services Task Force (USPSTF) advise against prostate-specific antigen (PSA) screening for men of all ages, while other guideline groups, including the American Urological Association (AUA) and the American College of Physicians (ACP), recommend a shared decision-making (SDM) approach to the PSA test.

Similar confusion occurred in 2009 prior to the launching of the Affordable Care Act and as recently as several months ago when the USPSTF in a proposed update did not recommend mammograms for women age 40 to 49. This proclamation has inspired some members of Congress to take to the airwaves to condemn quite vociferously a recommendation viewed as endangering lives. Yet, it is evident that overuse of medical technology can produce a cascade effect that results in the administration of even more diagnostic tests and subsequent treatment interventions, which may do nothing to improve a patient’s health status. From a policy standpoint, an upward spiral of unnecessary expenditures is an undesirable consequence. A more suitable alternative would be to engage in watchful waiting and continued surveillance before taking any further actions.

As an illustration, according to an article published on June 16, 2015 in the journal *BMJ*, the small inconsequential benefit seen from interventions that include arthroscopy for a degenerative knee is limited in time and absent at one to two years after surgery. Moreover, the procedure can be harmful. Taken together, the findings do not support the practice of arthroscopic surgery for middle aged or older patients with knee pain with or without signs of osteoarthritis.

Related matters pertain to polypharmacy (see p. 8 of this issue of the newsletter) and the use of nutritional supplements. An anti-angina drug may result in a painful bowel laceration while cessation of that medication has been shown to be the only effective treatment. Often, patients fail to reveal what substances they may be using in addition to prescribed medications and their providers do not inquire about such usage. Harmful interactions can occur between prescription medications and herbal supplements or high dose vitamins. Full disclosure by patients could lead to decisions that result in a willingness to avoid using substances that interact in non-beneficial ways. Hence, doing nothing rather than something may produce more salubrious outcomes in the long run.
Racism is man’s gravest threat to man - the maximum of hatred for a minimum of reason.

Abraham Joshua Heschel

The last couple of weeks have yielded some of the most dramatic events in the history of our country. There was the senseless killing of nine black church parishioners in Charleston by a deranged racist, the Supreme Court ruled that the Affordable Care Act (ACA) was Constitutional and the Supreme Court also ruled that same-sex marriage is now legal in every state. The Charleston murders also ignited an almost immediate movement to remove the Confederate flag from being displayed in most venues since it is often associated with slavery and racism. However, not everyone has had the same reaction to these events.

The ACA or Obamacare is still reviled by many despite the Supreme Court ruling. Regardless, it now appears the ACA will remain in place for the foreseeable future. Other individuals find same-sex marriage as completely contrary to their beliefs and something they cannot support. Finally there are those who view the Confederate flag as something that honors those who fought together in the Civil War and not as a symbol of racism. It’s clear that there are still strong feelings on many fronts and these recent developments will require slow but hopefully steady movement towards more acceptance and compromise in our society.

It is probably fair to conclude that not all of those involved in healthcare including our faculty, alumni, students, practitioners and patients hold the same views in regard to those emotional topics that I have highlighted above. However, it is one of the central tenets in all of our professions that we not allow our personal beliefs or biases to interfere with the manner in which we deliver quality care to those we serve. Nonetheless, there have been studies showing that racial and ethnic minorities often receive lower quality health care in our country. Socioeconomic status may actually be a better indicator of one’s ability to receive appropriate care. It’s a complex problem that is the subject of ongoing research.

As we continue to deal with the rapidly changing demographics and the underserved populations in this country it may be time to contemplate the question posed by Michael Hosokawa. He asks, “Is it time for health professions schools to critically examine their enchantment with high admissions test scores, grade point averages, race, and alumni parents and, instead, seek those characteristics we profess to want in health professionals?” He goes on to challenge those in the behavioral sciences to design the studies needed to help us in health professions education to select “students based on their compassion, perceptiveness, sensitivity, and empathy – in other words, from the inside out rather than the outside in.”

The events of the past two weeks require that we all take time to look inside ourselves and do a self-assessment to make sure we remain grounded in our core beliefs as these emotional issues continue to swirl around us. Perhaps these words from St. Francis of Assisi say it best:

Where there is hatred, let us sow love; where there is injury, pardon; where there is discord, union; where there is doubt, faith; where there is despair, hope; where there is darkness, light; where there is sadness, joy.

I hope you have a productive yet relaxing summer and look forward to seeing all of you at our upcoming annual meeting in Scottsdale.

Rich

CBO DYNAMIC SCORING OF LEGISLATION

Thousands of bills are introduced in each session of Congress. Although the vast majority never move beyond the initial stage of introduction, more important items undergo a process by the Congressional Budget Office (CBO) known as “scoring.” During a hearing before the Senate Budget Committee, Keith Hall, the new director of the CBO, explained that the agency would begin incorporating dynamic scoring for certain legislation, particularly for changes to health care policy. He specifically referred to health care because of recent spending growth in the U.S.

The incentive to incorporate more dynamic scoring is the result of Congress passing a concurrent resolution for the fiscal year 2016 budget. The resolution requires CBO to incorporate the updated scoring technique “to the greatest extent practicable” for major legislation. The conversion from static scoring to dynamic scoring likely will affect future legislation having an impact on Medicare, Medicaid, and other federal health programs, along with any potential modifications to the Affordable Care Act.

Since the budget process began in 1974, the CBO has used a similar scoring methodology to evaluate policy effects on federal spending and revenues. That process only examines microeconomic changes, whereas dynamic scoring takes into account macroeconomic effects and estimates the impacts that policies have on economic growth and employment. The new methodology can give a more complete picture of the economic effects of policies to determine that their full influence is considered.

Dynamic analysis, however, requires assumptions about future policy changes and is extremely sensitive to those assumptions, which can lead to distortions of its own. Meanwhile, the CBO has been training new analysts to be able to use this new scoring on the health care industry and future projections.

Examples of when scoring may occur involve the following bipartisan bills passed by the House of Representatives this year that deal with the Medicare Advantage Program:

- H.R. 2570, the Value-Based Insurance Design for Better Care Act of 2015
- H.R. 2507, the Increasing Regulatory Fairness Act of 2015
- H.R. 2505, the Medicare Advantage Coverage Transparency Act of 2015
- H.R. 2582, the Securing Seniors’ Health Care Act of 2015

The first three bills were scored as budget neutral, according to the CBO. The fourth bill, H.R. 2582, would result in $30 million in savings. As an illustration of why these bills are of considerable importance, H.R. 2570 includes provisions related to electronic health records (EHRs) for ambulatory surgical centers (ASCs) and reimbursement for infusion drugs under the Medicare Part B durable medical equipment (DME) benefit.

2015-2016 ASSOCIATION CALENDAR OF EVENTS

October 28-30, 2015—Annual Conference in Scottsdale, AZ

Dates/Site for the 2016 Spring Meeting being negotiated

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

Aftermath Of Supreme Court Ruling On The Affordable Care Act

Republicans who were confident that the ruling by the Supreme Court in the case of King v. Burwell would prove to be favorable found it necessary when the decision was announced on June 25 to change their way of thinking. Instead of being compelled to deal with the prospect of the potential carnage that would result from having more than six million beneficiaries in 36 states lose federal subsidies that enable them to afford the purchase of health insurance premiums, GOP members once more were confronted, as they were in 2012 by another lifesaving court ruling, with the reality that the Affordable Care Act continues to remain intact.

Once the dust settles from this judicial setback, congressional Republicans will have to decide just how much effort they wish to expend on repealing the ACA either in whole or in part. One legislative strategy is available, but pursuing it does not mean that President Obama ever would agree to sign it into law in the event it even reaches his desk. Known as budget reconciliation, this particular tool pertains to spending and revenue provisions in the law. The aim would be to deny funding that is necessary to implement different aspects of the ACA.

A key attractive feature is that such legislation could move forward without being delayed or terminated by a protracted filibuster. Just as importantly, it would not be necessary to adhere to a 60-vote threshold in the Senate. If this initiative is attempted, its legislative viability is derived from broad reconciliation language contained in the budget resolution that was passed earlier this year. Reconciliation was used in 2010 as a means of enacting the ACA.

Proposed Legislation For Repealing Portions Of The Affordable Care Act

Apart from efforts to gut the law through Supreme Court rulings, less ambitious means still are available in concerted attempts to eliminate particular features of the law. H.R. 1190 (The Protecting Seniors’ Access to Medicare Act of 2015), legislation to repeal the Independent Payment Advisory Board, passed in the House on June 23 on a vote of 244-154, which included support from 11 Democrats. The Senate companion bill (S. 141) currently has 40 cosponsors, all Republicans. H.R. 160, the Protect Medical Innovation Act, to repeal the ACA’s medical device tax passed in the House on June 18 on a vote of 280-140, which included 46 Democrats. Related targets for repeal are both the employer and individual mandates to purchase health insurance.

Projected Economic Impact Of Repealing The Affordable Care Act

Given the two rulings by the Supreme Court, along with the strong unlikelihood that President Obama would sign any legislation to repeal the ACA, large scale dismantling on a scale of eliminating the law does not appear to be on the near horizon. Nevertheless, if that day ever occurs, there will be economic consequences. According to a new report released by the Congressional Budget Office (CBO) in June 2015, using traditional scoring practices it was revealed that repealing the ACA would increase budget deficits by $353 billion over the next decade. That amount is substantially larger than the last time an estimate was made in 2012. Back then, it was projected that repeal would cost $109 billion.

The CBO and the Joint Committee on Taxation (JCT) also conducted a dynamic score to estimate what repeal of the ACA would cost and found that the national debt would increase by $137 billion over the next ten years. This projection is the first dynamic cost estimate conducted by the CBO and JCT since new congressional rules requiring the dynamic scoring of major legislation took effect earlier this year (see article on page three of this issue of the newsletter for more information). This approach takes into consideration the macroeconomic effects of the law.

As mentioned at the top of this page, if Republicans attempt to use reconciliation as a repeal mechanism, the CBO estimate could serve as a significant hurdle to overcome because any such measure must be aimed at reducing the federal deficit.
TRENDS IN HIGHER EDUCATION

The Senate Committee on Health, Education Labor & Pensions conducted a hearing on June 17, 2015 entitled, “Reauthorizing the Higher Education Act: Evaluating Accreditation’s Role in Ensuring Quality.” Testimony was presented by:

Anne D. Neal, President Of The American Council Of Trustees And Alumni

The mere mention of accreditation typically evokes the glazing over of eyes and a rapid escape from the room (Editor’s Note: the room did not empty). Accreditation is a regulatory policy whose application is having real, and I will argue negative consequences, in the lives of students and taxpayers. We must redesign and reform quality assurance to strengthen the quality of colleges and universities, promote competition and innovation and provide accountability. To do that, we must end accreditation as a gatekeeper for Title IV. I would submit to you: that premise was fundamentally wrong. We have had 60 years of experience with this. While this system has been in place, quality has gone down; debt has gone up to record highs; and the quality of American higher education is being questioned more than ever before.

Peter T. Ewell, Vice President National Center For Higher Education Management Systems

The ideas that I want to share with you are anchored in two central convictions. First, I believe that the practice of institutional accreditation currently falls far short of the model that we as a nation should possess for a credible and consistent guarantor of educational quality. Second, I believe strongly that fixing accreditation is far preferable to scrapping it in favor of an unknown, untested alternative operated by the federal government or the states. Only a few of our state oversight authorities, meanwhile, have the requisite capacity to discharge this function; most are understaffed and under-capitalized and would have to be beefed up considerably (again at significant public expense) to discharge this responsibility adequately. Reform proposals into three categories of ascending difficulty or challenge were offered.

Albert C. Gray, President And CEO, Accrediting Council For Independent Colleges And Schools

Three considerations to inform the legislative task of reauthorizing the Higher Education Act and strengthening the system of voluntary quality assurance known as accreditation were presented: 1. Know the students, understand their unique needs and circumstances, and use that knowledge to shape higher education policy. 2. Inventory the depth of rigor and review that is applied through the quality assurance process and build policy that empowers and strengthens the value of that process. 3. Encourage the accreditation community to play a broader role in defining the measures of value incorporated in the price/value proposition. This role is uniquely the obligation of accreditation, and when it is played effectively, the relationship between price and value is kept in balance.

George Pruitt, Chairperson, Middle States Commission On Higher Education (MSCHE)

I have a relatively long history of working on accreditation for my institution and in both regional and national organizations. I believe in it and I believe that individual institutions and American higher education benefit from the self-study, peer review and related processes. Further, I believe that accreditation is a fundamentally sound system. The common criticism of accreditation is that it takes too long, costs too much, and doesn’t have enough value. However, evidence from MSCHE’s accredited institutions suggests different conclusions. All regional accrediting agencies, including Middle States, continue to develop and improve accreditation. Many of the agencies have recently been engaged in revising accreditation expectations and standards.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Underage Drinking
Underage drinking in the U.S. decreased from 28.8% in 2002 to 22.7% in 2013, according to new data from the Substance Abuse and Mental Health Services Administration (SAMHSA). During that period, underage binge drinking – having five or more drinks on the same occasion – decreased from 19.3% to 14.2%. Despite those declines, in 2013, about 8.7 million individuals aged 12 to 20 reported drinking alcohol in the past month and 5.4 million were current binge drinkers.

Health Insurance Coverage
According to a report that was released by the National Center for Health Statistics (NCHS) in June 2015, in 2014, 36.0 million persons of all ages (11.5%) were uninsured at the time of interview, 51.6 million (16.5%) had been uninsured for at least part of the year prior to interview, and 26.3 million (8.4%) had been uninsured for more than a year at the time of interview. Among persons under age 65, 63.6% (170.4 million) were covered by private health insurance plans at the time of interview, which includes 2.2% (5.9 million) covered by private plans through the Health Insurance Marketplace or state-based exchanges at the time of interview between January and December 2014. The proportion with exchange coverage increased from 1.4% (3.7 million) in the first quarter of 2014 (January–March) to 2.5% (6.7 million) in the fourth quarter of 2014 (October–December).

Meeting Aerobic-Activity And Muscle-Strengthening Guidelines
According to Morbidity and Mortality Weekly Reports (MMWR) of June 19, 2015, the percentage of adults aged ≥18 years who met the aerobic-activity and muscle-strengthening guidelines increased from 18.2% in 2008 to 20.8% in 2013. Adults aged 18–44 years were the most likely to meet the aerobic-activity and muscle-strengthening guidelines, and those aged ≥65 years were the least likely in both 2008 and 2013. For all age groups, the percentage meeting the guidelines increased from 2008 to 2013.

HEALTH TECHNOLOGY CORNER

Body On A Chip
Technological advances involving chips made of plastic or other materials hold promise for discovering how organs will respond to new drugs. Currently, drug tests are conducted on animals or in rows of cultured dishes. As an alternative, human cells can be attached to chips and given the proper conditions, these cells will respond as if they were in a human body. They receive sustenance by a blood-mimicking fluid. A liver on a chip was developed at the University of Oxford as a means of searching for a cure for hepatitis B. Researchers at Harvard University are working on a lung on a chip while a heart on a chip is under development at the University of California, Berkeley. Other body organs such as the kidney are being investigated in similar ways. A major aim is to acquire the ability to link several chips together to study how a reaction in one organ can affect other organs. These ventures have the potential to accelerate drug testing minus the problems associated with using animals and relying on cultured dishes.

Wearable Devices To Set And Track Health Goals
A veritable explosion in the form of innovative technologies, including wearable devices have been developed to encourage a regular focus on health by setting and tracking health goals. Thousands of apps exist, along with approximately 80 different kinds of wearable devices that are available to manage health status. A latest entrant to the field is a pilot device at King's College Hospital in London that will enable cancer patients moving through chemotherapy treatments to manage their medication usage through features on an Apple Watch.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Impacts And Implications Of Rising Out-Of-Pocket Health Care Costs

A Deloitte analysis revealed that consumers’ out-of-pocket (OOP) purchases add considerably to the total cost of health care. Nutritional supplements make up the largest portion of costs not included in the National Health Expenditure Accounts (9%), followed by spending for complementary and alternative medicine providers (5%). Ideally, consumers seeking to reduce OOP costs will take time to research options and use available tools to select low-cost, high-quality providers in their health plan’s network. People facing high cost-sharing may be discouraged from using many of the health services they need, including help managing chronic health conditions, and may not see the value in paying premiums for future coverage. The report can be accessed at https://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-lchs-dig-deep-hidden-costs-112414.pdf.

Telemedicine: The Promise And Challenges

The integration of technology and health care is on the rise. Although evidence shows that telemedicine has improved access to health care and resulted in lower costs in rural and underserved areas, challenges to expansion include reimbursement policies and acceptable security measures. An Alliance for Health Reform Toolkit addresses the effectiveness of telemedicine as a tool for communication as well as the expected outcomes and challenges ahead. The toolkit can be accessed at http://allhealth.org/publications/AHR-Telemedicine-Toolkit_June-2015_164.pdf.

Engaging Consumers In Changing Health Behaviors

As a means of having a positive impact on workforce health and reduce costs, employers must move their health programs beyond words to a state of consumer engagement and action. An article from Buck Consultants at Xerox summarizes relevant concepts and findings from the fields of psychology, decision research, and social marketing and identifies best practices in developing consumer engagement. Employers can use this information when creating health care programs and tools to control costs and improve workforce health and productivity. The article can be accessed at http://www.xerox.com/downloads/usa/en/buck/whitepapers/hrc_wp_eng_changing_health_behavior.pdf.

Improving Safer Health Care Through Increased Transparency

The National Patient Safety Foundation’s Lucian Leape Institute produced a report that offers sweeping recommendations to bring greater transparency in four domains: between clinicians and patients; among clinicians within an organization; between organizations; and between organizations and the public. It makes the case that true transparency will result in improved outcomes, fewer medical errors, more satisfied patients, and lowered costs of care. The report can be accessed at https://c.ymcdn.com/sites/npsf.site-ym.com/resource/resmgr/LLI/Shining-a-Light_Transparency.pdf.

Development Of Effective Care Models In Advanced Chronic Illness

The Coalition to Transform Advanced Care (C-TAC) and the AHIP Foundation released a framework to guide the development of effective care models for patients with advanced chronic illness. The framework can be accessed at http://www.thectac.org/wp-content/uploads/2015/06/ACP-Report-6-18-15-FINAL.pdf.
WORRISOME ASPECTS OF POLYPHARMACY

Mandated by Congress, twice each year the Medicare Payment Advisory Commission (MedPAC) is required to issue reports. The June 2015 report contains information about some problems associated with polypharmacy (as mentioned on page one of this issue of TRENDS). A concern is that multiple prescription drugs (polypharmacy) can affect patients’ medical conditions and lead to additional service use. Studies have found a positive association between polypharmacy and adverse events, such as hospitalization and emergency department visits, and nonadherence to appropriate medications. When opioids are included as part of a multiple-drug regimen, problems related to adherence and adverse drug events (ADEs) become even more pronounced.

The relationship between medication adherence and health spending for individuals who are treated with multiple medications can be more complex than it is for individuals treated with a single medication or very few medications. For example, adhering to multiple drug regimens could result in drug–drug interactions that may affect a patient’s medical condition and lead to additional physician visits, emergency department visits, or hospitalizations. Adverse effects from polypharmacy can occur when a patient is prescribed more drugs than are clinically warranted or when all prescribed medications are appropriate, but the total is too many for a patient to ingest or manage safely.

Individuals ages 65 and older, who are more likely to suffer from multiple chronic conditions, are at high risk for ADEs associated with polypharmacy, yet there are few clinical guidelines pertinent to prescribing and managing multiple prescription drugs among this population. For example, a study by the Centers for Disease Control and Prevention (CDC), using data drawn from the National Electronic Injury Surveillance System–Cooperative Adverse Drug Event Surveillance Project, estimated that from 2007 through 2009, about 100,000 emergency hospitalizations among the elderly for adverse drug events occurred annually. Nearly half were among adults 80 years and older. More than half of the ED visits that resulted in hospitalizations involved patients taking five or more concomitant medications.

BROWSING THE HEALTH WORKFORCE PROFESSIONAL LITERATURE

The March 2015 issue of the American Journal of Audiology contains a paper describing a study aimed at assisting monolingual English-speaking audiologists working with Spanish-speaking Hispanic patients by developing appropriate cultural and language instruction materials. Test descriptions and instructions for hearing and balance tests were developed in both languages. Overall, ratings from audiologists and nonaudiologists indicated the translations were easy to understand, and the wording/dialect was appropriate for the region. Audiologists generally reported the information was consistent with what they use clinically, although variability existed in specific wording used. Reviewers rated a cultural training module as easy to understand, relevant to Spanish-speaking patients, and relevant to audiologists. The materials were revised and edited based on assessments from reviewers. The final translations are provided as online supplemental materials.