TERRA INCOGNITA: HEALTH WORKFORCE PLANNING

According to a health workforce-related article published on November 18, 2015 in the journal *PLoS One* on the topic of trainable observers of pathology and radiology breast cancer images, pigeons (*Columba livia*) can serve as promising surrogate observers of medical images. Birds in a study proved to have a remarkable ability to distinguish benign from malignant human breast histopathology and proved to be similarly capable of detecting cancer-relevant microcalcifications on mammogram images. They learned in only a matter of hours to do better than random at distinguishing cancerous from non-cancerous cells. Over the course of just one month, their accuracy rose as high as 80%, which is good, but not as good as human experts. Far more impressive was the wisdom of the flock. By showing the same images to different birds and combining their guesses, the accuracy rose to 99%, on par with trained human experts and far more reliable than a computer doing automatic image analysis.

Although it would appear to be a flight of fancy and perhaps even a bird-brained notion to consider including pigeons in the diagnostic ranks of health care practitioners, this finding triggers some thoughts about the ways in which technology and related developments could have an impact on the future composition of the health workforce in the U.S. While efforts have been made over the decades to develop forecasts of how many physicians will be needed, the same cannot be said for professions included under the rubric of allied health.

Demography to a significant extent is destiny and what is known about the population of the U.S. is not only that it is aging, but that individuals in older cohorts have multiple chronic health problems. Some factors in the form of possible major challenges that need to be taken into account when trying to estimate which health personnel will be necessary include:

- The kinds of health problems experienced by patients.
- Patient demands for health care services with an emphasis on distinguishing between their needs and wants.
- Adequacy of financing mechanisms that enable patients to afford health care since high deductibles and co-payments could serve as important deterrents.
- Consumer preferences regarding the nature of health care services from the perspective that virtual health care may serve as an acceptable proxy for office and clinic visits.
- Changing patterns of delivery from the acute care inpatient setting to other venues where services can be provided in the home and at retail clinics.
- Attributes of a health career that will prove beneficial enough to attract students to the health professions and keep them from departing early to other careers.
- Scope of practice rules that should be changed to enable practitioners with appropriate skill sets to provide care safely for patients who are afflicted with certain kinds of health problems.
PRESIDENT’S MESSAGE
By Linda Petrosino, ASAHP President

The Mission of ASAHP is “to improve health...through excellence in interprofessional education, collaboration, leadership, research, and advocacy.”

The Vision of ASAHP is, “By 2020, ASAHP is a leading interprofessional voice for better health and healthcare.”

Dear Colleagues: This message is being prepared the day before Thanksgiving, the traditional time when we pause for a reflection of gratefulness and thanks for our bounty. After identifying the gratefulness for family and friends I turn to the deep appreciation that I have for the decades of so many professional colleagues. Thank you for being part of a rewarding professional journey.

The next part of the professional journey is the responsibility that I accepted with the passing of the gavel during October’s Annual Conference. It is with a sense of sincere respect for, and confidence in, the strength of the membership, the Board of Directors and the staff in the national office that I look forward to the next two years of team work that will advance our collective goals.

The last two years benefitted from the leadership of Rich Oliver, Immediate Past President. In his inaugural newsletter address he stated, “I want to strive to assure that ASAHP’s work and goals are relevant to you and your institutions.” The Strategic Plan and related activities assured the relevance and provides a blueprint from which to continue to progress.

It is important to note and collectively reaffirm the above stated vision and mission of the organization. To continue the work of the Association, I have spent the last 3-4 initial weeks of the presidency working with the Strategic Plan that was revisited and slightly revised during the October Board meeting. With input from the Board, three major tactical objectives (Advocacy, Clinical Education, Corporate Alignment and Partnerships) have been identified that articulate with and overlap with one or more of the Five Strategic Plan Priorities, which are (Interprofessionalism, Advocacy, Innovation and New Services, Alliances and Partnerships, Marketing, Promotion, and Growth).

All five areas have been assigned a Board liaison, committee chair(s), and committee members to begin work, and in some cases continue their already good work in completing tasks/projects that help realize the stated objectives and priorities. The Board and the committee members are certainly a group of committed people with their eye on the mission of the organization and moving us with strength into the future. As their works unfold, periodic reports will be provided to the membership.

As I close out this message, I would be remiss not to mention the challenging times globally as well as in our own backyards on our campuses. We see a world of conflict and competing values. We see a national movement on campuses that demand a closer examination of principles, values and behavior. We need to ask ourselves what is our role as individual leaders in making our environments a place where people can continue to learn and what is our role as members of an Association that strives to be “a leading interprofessional voice for better health and healthcare by 2020?”

We do not necessarily have easy work ahead of us; it is difficult to imagine work that is more important. It is a sincere privilege to work with you as we make steps to achieve our ambitious vision.

Linda
REPEAL OF THE AFFORDABLE CARE ACT

Ever since the Affordable Care Act became law in March 2010, Republican members of Congress have tried on numerous occasions to repeal it either in whole or in part. A manifestation of that effort occurred prior to a week-long adjournment for the 2015 Thanksgiving recess. This time around, the attempt is being made using reconciliation legislation. Somewhat ironically, that same mechanism was employed to achieve passage of the health reform legislation in the first place.

Prior to the recess, Senate Majority Leader Mitch McConnell (R-KY) took action by using a procedural motion to allow reconciliation legislation to bypass the Senate’s committee process so that it could be placed directly on the Senate calendar for action on the floor. He assured his party colleagues that the package will include repeal of Planned Parenthood funding. Not all members of his own party agree that the provision should be included. In order for reconciliation to pass, 51 senators will have to approve the measure. Although there are 54 Republican senators, there is no guarantee that all will vote in favor. Apart from naysayers about the Planned Parenthood funding component, opposition may arise from Republican colleagues who believe that reconciliation does not go far enough in its scope. They want full repeal of the Affordable Care Act. (See page seven of this newsletter for more information about reconciliation.)

Meanwhile, one aspect of health reform is generating bipartisan support in favor of repeal. Known as the “Cadillac Tax,” a group of Democrats and Republicans have requested a meeting with President Obama to discuss eliminating it. If it takes effect in 2018 as expected, this 40% levy will have an impact on health insurance plans with costs exceeding $10,200 for individuals and $27,500 for families. One type of concern is that the tax will shift costs to patients. Many unions that usually take the side of Democrats on most key issues worry that future salary increases will be jeopardized. If repeal of this provision does occur, however, the Administration will be faced with the problem of losing an important source of tax revenue that is necessary to pay for other components of the Affordable Care Act. It is estimated that $91 billion would be lost over a 10-year period.

Apart from health reform legislation, much work is needed to complete appropriations for FY 2016. A bipartisan group of more than 100 members of the House of Representatives has petitioned that chamber’s Appropriations Committee in support of a funding boost for the National Institutes of Health (NIH). An objective is to have $32 billion appropriated, which represents $2 billion more than the spending level for the fiscal year that ended on September 30, 2015.

2015-2016 ASSOCIATION CALENDAR OF EVENTS

November 30, 2015—Institutional Profile Survey Data Collection Period Closes

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
ASAHP President Richard Oliver Passes The Gavel To Incoming President Linda Petrosino

ASAHP Secretary Celia Hooper Is The Recipient Of The Outstanding Member Award
2015 ASAHP ANNUAL CONFERENCE

Plenary Sessions Enable Participants To Hear The Views Of Top Presenters

Networking Continues To Be An Important Aspect Of Every ASAHP Meeting
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Identifiable Health Information Data Breaches
Verizon Enterprise Solutions on November 9, 2015 unveiled select initial findings from its inaugural Protected Health Information (PHI) Data Breach Report, in which the following are examined: how PHI breaches happen, how long it takes to discover a breach, how PHI breaches affect the doctor-patient relationship, and how to mitigate the risks. (PHI is defined in the report as personally identifiable health information on an individual covered by one of the state, federal, or international data breach disclosure laws.) A whopping 90% of industries have experienced a PHI data breach, including breaches of health insurance information from personnel files or other breaches outside of traditional healthcare settings or industries. Incidents from 25 countries were examined, including detailed analysis of confirmed breaches involving more than 392 million records and 1,931 incidents. While medical record data often are taken with malicious intent, it frequently is the personable identifiable information (PII) that attackers seek.

Long-Term Care Providers’ Use of Electronic Health Records
According to the Centers for Disease Control and Prevention (CDC), in a National Study of Long-Term Care Providers, in 2014 nearly one fourth (23%) of adult day services centers used electronic health records (EHRs), and fewer than 10% had a computerized system that supported electronic health information exchange with physicians (8%), pharmacies (6%), and hospitals (6%). About one-fifth (19%) of residential care communities used EHRs, and 11% had a computerized system that supported electronic health information exchange with physicians, 17% with pharmacies, and 8% with hospitals.

HEALTH TECHNOLOGY CORNER

“Hearing” Tumors Grow
A new technology has promise to find buried plastic explosives safely and maybe even be able to detect fast-growing tumors. According to a report in Applied Physics Letters, Stanford University electrical engineers believe that the careful manipulation of two scientific principles drives both military and medical application. All materials expand and contract when stimulated with electromagnetic energy, such as light or microwaves. This expansion and contraction produces ultrasound waves that travel to the surface and can be detected remotely. Capacitive micro-machined ultrasonic transducers can specifically discern weaker ultrasound signals that jump from the solid, through the air, to the detector. Since all measurements are made through the air, the goal is to use the device in medical applications without touching the skin. Prior medical research has shown that tumors grow additional blood vessels to nourish their cancerous growth. Vessels absorb heat differently than surrounding tissue, so tumors should show up as ultrasound hotspots.

Study Of Mobile Health Impact On Cardiovascular Disease
Funded by a five-year grant from the the National Institutes of Health (NIH), researchers at the University of California, San Francisco will create Health ePeople, a platform to study mobile and wireless health outcomes for cardiovascular disease. The project will gain access to a cohort of volunteers that may grow as large as one million volunteers whose health data will be collected through mobile and wireless technologies affordably. Health ePeople will collect mobile health data from sensors, devices, apps, and data from online surveys and electronic health records to study clinical outcomes. Collaboration is planned with other mHealth initiatives, including the NIH Precision Medicine Initiative and the national Patient-Centered Clinical Research Network (PCORnet), an initiative of the Patient-Centered Outcomes Research Institute (PCORI).
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Changes In Medicare Spending Per Beneficiary By Age

A paper from the Congressional Budget Office (CBO) provides estimates of how Medicare spending per beneficiary for patients of different ages and for different types of services has changed in recent years. The aging of the population exerts upward pressure on federal spending for health care, especially Medicare, as both the number and average age of elderly beneficiaries increase. Total Medicare expenditures also may be affected by changes in relative per-beneficiary spending for beneficiaries of different ages as the population ages. In this paper, the Master Beneficiary Summary File was used to estimate spending per beneficiary for the population segment between ages 65 and 105 enrolled in the traditional fee-for-service (FFS) Medicare program between 1999 and 2012. Over that period, the age for which Medicare spending per beneficiary was highest increased from 89 to 97. In addition, spending per beneficiary grew faster for older beneficiaries than for younger ones in the second half of the period. The report can be accessed at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/workingpaper/51027-MedicareSpending.pdf.

Policy Implications Of House Reconciliation Bill Regarding The Affordable Care Act

Republican members of Congress view budget reconciliation as a suitable vehicle for repealing sections of the Affordable Care Act that they find to be objectionable. Reconciliation is an optional, expedited legislative process that consists of several stages, beginning with the adoption of the budget resolution. A report from the Congressional Research Service (CRS) provides background on the reconciliation process and summarizes the provisions in H.R. 3762, including their projected budgetary impact. It then briefly examines some of the bill’s policy implications. The report can be accessed at http://fas.org/sgp/crs/misc/R44238.pdf.

High-Priority Evidence Gaps for Clinical Preventive Services

In 2015, the U.S. Preventive Services Task Force (USPSTF) continued to fulfill its mission of improving the health of all Americans by making evidence-based recommendations about clinical preventive services such as screening tests, counseling about healthy behaviors, and preventive medications. These recommendations help primary care clinicians and patients to decide together whether a preventive service is right for each patient’s needs. In this annual report, the USPSTF has prioritized evidence gaps related to women’s health. Research in these areas would generate much needed evidence for important new recommendations to improve the health and health care of women in the United States. The report can be accessed at http://www.uspreventiveservicestaskforce.org/Page/Name/fifth-annual-report-to-congress-on-high-priority-evidence-gaps-for-clinical-preventive-services.

Accelerating The Adoption Of Connected Health

According to a new paper from the Deloitte Center for Health Solutions, prompted by an increased demand for value and connectivity, health care organizations are making services more accessible and potentially less expensive while enabling “anytime and anywhere” patient-provider connectivity through Connected Health (cHealth). cHealth is transforming the patient-provider relationship with technology-enabled, integrated care delivery that facilitates remote communication, diagnosis, treatment, and monitoring. The paper can be accessed at http://www2.deloitte.com/content/dam/Deloitte/us/Documents/life-sciences-health-care/us-dchs-connected-health.pdf.
ENVISIONING THE HEALTH WORKFORCE OF TOMORROW

The article on page one of this issue of the newsletter indicates certain factors that contribute to the difficulty of determining the composition of the health workforce of tomorrow. The U.S. is undergoing significant changes that will play a role in shaping the dimensions of that workforce. Not only is the population aging, it continues to grow in overall size and shifts are occurring in the direction of a steadily declining portion of Americans who are classified as Caucasians. Given this situation, it helps to gather information from a wide range of sources as a means of trying to make projections of not only what the health workforce of the future might look like, but also consider what it should look like. The following resources may help to enhance such an analysis.

Along The Care Continuum
The American Hospital Association (AHA) recognizes that the workforce must change how it functions on multiple levels. Care must be provided by interprofessional teams where work is role-based, not task-based, and the team must be empowered to create effective approaches for delivering care. Hospitals can serve as conveners and enablers in primary care delivery. Primary care should be integrated into current and future care systems, and hospitals should form effective partnerships with the community and patients in a way that provides the infrastructure primary care teams need to deliver quality care. The patient and family are essential members of the core care team. Bedside care team members are fully engaged at the broadest scope of their practice. Technology replaces some clinical tasks, augmenting decision-making and complementing the clinical judgment of the care team. Patients needing acute care move safely through the health care system no matter where they are in the care cycle – whether at the onset of disease, in the middle of community-based care, or at the end of life.

Time For A Makeover In The New Health Economy
PricewaterhouseCooper’s Health Research Institute (HRI) suggests that with the emphasis on giving purchasers greater value for their healthcare dollar, do-it-yourself consumers and integrated care teams armed with a black bag of virtual tools are poised to reinvent primary care and close the gap. Rather than playing its historic role as gatekeeper to a scattered array of specialties, primary care has to become the nexus, providing simplicity, value, and better health outcomes. Doing so will mean taking risks and challenging old assumptions. Consumers are selecting primary care that fits their lifestyles. As busy individuals take on greater responsibility for their health bill, many by-pass the family doctor. Yet about eight in 10 consumer survey respondents said they would be open to non-traditional ways of receiving basic medical attention. New entrants are disrupting the health industry with innovative primary care models. Newcomers offer convenience and value to consumers and purchasers through five modern options: convenient care, house calls, at-your-service care, digital health, and nurse-led care.

Digital Connectivity Between Providers And Patients
As noted on page seven of this newsletter, cHealth is technology-enabled integrated care delivery that allows for remote communication, diagnosis, treatment, and monitoring. An important goal of an effective, patient-centered cHealth approach is to improve digital connectivity between providers and patients to allow individuals to access the care they need. cHealth solutions span applications (apps), smart devices (wearable and non-wearable), aggregation platforms, and analytics, creating business models across the “information value loop.” Data integration challenges, privacy and security concerns, and provider resistance to adopt new business models have slowed cHealth adoption. The promise of cHealth is exciting, but remains far from being fully realized, mostly because the marketplace lacks strong incentives for providers, payers, and consumers to embrace cHealth technologies fully. Many providers still operate in a fee-for-service (FFS) world. Although widespread adoption of electronic health records (EHRs) is occurring, the transition to a value-based, connected health care system still is in its early stages.