PHILOSOPHY AND HEALTH TECHNOLOGY CROSSROAD

As reported in the March 2017 issue of the journal *Philosophy and Technology*, on February 16 of this year the plenary session of the European Parliament voted in favor of a resolution to create a new ethical-legal framework according to which robots may qualify as “electronic persons.” In health care, robots and artificial intelligence solutions are combining with nurses, physicians, social workers, technicians, and experts, such as radiologists, by helping perform functions that, just a few years ago, were considered off-limits for technological disruption: cataloguing images, suggesting diagnosis, monitoring and even moving patients, interpreting radiographies, controlling insulin pumps, and extracting new health care information from huge data sets. Any job in which humans serve as menial interfaces, e.g., adjusting the dose of a medication for a patient, is at risk. Such developments suggest the need for new ethical solutions for the *infosphere* in order to determine which forms of artificial agency and interactions should flourish.

Health care robotics is an example of a portion of the medical device industry that continues to grow at an impressive pace. Robots represent varying levels of autonomy ranging from one kind that depends exclusively on commands issued by human operators, e.g., using a prosthetic, to a higher level of autonomy in which a robot performs a surgical procedure that is overseen by humans.

A major concern is that technology may advance at a much faster rate than regulatory, ethical, and legal frameworks. As noted in the March 15, 2017 issue of the periodical *Science Robotics*, as the level of autonomy increases, so will regulatory challenges. At some point, a robot is not only a medical device, but is also practicing medicine. The FDA regulates medical devices, but not the practice of medicine, which is left to the medical societies. Handling the overlap will be challenging and require the involvement of multiple responsible parties. Implications also will vary for the same level of autonomy, but in different usage contexts that depend on whether a robot is performing home-assistive tasks, e.g., bringing medications to a patient, or functioning in a surgical suite.

Related considerations from a philosophical standpoint currently may seem exceptionally fanciful and more in the realm of science fiction, but developments in regenerative medicine continue to be pursued. As noted one year ago this month in the journal *Neuroethics*, the possibility of a human head transplant poses unprecedented philosophical and neuroethical questions. Principal among them is the personal identity of the resultant individual, regarding metaphysical and social status.

Who will this individual be and how should the “new” person be treated - morally, legally, and socially - given that a head transplantation incorporates characteristics of two distinct, previously unrelated individuals, and possesses both old and new physical, psychological, and social experiences that would not have been available without the occurrence of this transformation?
This month’s invited guest sharing some thoughts is ASAHP Board Member Peggy Valentine, who is Dean of the School of Health Sciences at Winston-Salem State University. She serves as Chairperson of the Advisory Committee on Interdisciplinary, Community-Based Linkages at the Health Resources and Services Administration (HRSA). Her views regarding the Advisory Committee are as follows:

It was in December 2013 that I received a letter from former Secretary of Health and Human Services (HHS) Kathleen Sebelius, inviting me to join the Advisory Committee on Interdisciplinary, Community-Based Linkages, (ACICBL). What an amazing experience it was to work with a nationally representative group of physicians, social workers, nurses, physician assistants and allied health professionals. This brief report provides a snapshot of my experiences in serving the federal government and representing the voice of allied health.

The ACICBL provides advice and recommendations on policy and program development to the Secretary of HHS under Title VII, Part D of the Public Health Service Act. Allied Health is one of the legislatively mandated programs, although it has not received funding since 2005.

Each year, the ACICBL selects a topic concerning a major health issue within the health care delivery system relevant to the health workforce. In preparing these reports, various topic experts are identified to share current information with committee members during the meetings. The committee uses this information, researches other related information with HRSA staff and discusses pertinent information in generating the report.

During my tenure, the committee elected me as Vice Chair and I became Chair of the committee in 2016. We worked on three reports. The 14th report was titled, “Rethinking Complex Care: The Healthcare Workforce to Foster Person-Centered Care,” published in June 2015. This report is free of charge and can be located on HRSA’s website. It highlights the importance of quality training of health professionals in interprofessional settings, the value of shared decision-making for improved health care outcomes, the need for a culturally competent diverse health professional workforce and the empowerment of patients to engage in their care.

Two exciting reports that are in the final stage of editing include the 15th and 16th reports. The 15th report on, “Programmatic Review of Title VII, Part D Programs” includes a recommendation to restore funding of allied health projects to the 2005 levels with a modest increase in funding. The rationale supports the need for allied health to address an aging population, improve access to care, and support interprofessional education and practice. I am hopeful that the recommendation to restore allied health funding will be supported.

The 16th report is on “Clinical Training Sites,” Most understand the shortage and competition for clinical sites are national issues. Some recommendations in the report include the development of a National Center for Clinical Sites, providing student stipends, nonmonetary incentives for preceptors and possible tax incentives, IPE through simulation and online education. The 15th and 16th reports should be available via the HRSA website later this year.

It was indeed a pleasure to serve and represent allied health on a national level. It was a greater pleasure to clear misconceptions and provide a definition of allied health, especially when called, “paraprofessionals.” In my opinion, it is everyone’s responsibility to promote allied health, whether at the local, regional and national levels. There is a tendency to cite specific disciplines in our writing, and not so much allied health. We all can market the allied health professions, and increase our presence by contributing to the body of allied health knowledge in a greater way. In so doing, we educate the public on our contributions and relevance.
FEDERAL SUPPORT FOR HIGHER EDUCATION

The guest article by ASAHP Board Member Peggy Valentine on page two of this issue of the newsletter cites work undertaken by the Advisory Committee on Interdisciplinary, Community-Based Linkages at the Health Resources and Services Administration (HRSA), a group on which she serves as Chairperson. An important function is to issue reports to the Secretary of the Department of Health and Human Services (HHS) and Congress. Both sets of entities should be concerned about her reference to the fact that although Allied Health is one of the legislatively mandated programs, it has not received funding since 2005.

As in previous years, Congress is laboring strenuously to produce a federal budget for fiscal year 2018, which begins next October 1. Apart from reigniting a funding stream for allied health, federal support for higher education is of great concern. Alarm bells were sounded when the Trump Administration released a “skinny budget” proposal last month. It generated criticism because it would appropriate $3.9 billion dollars from the surplus fund of the Pell Grant program, which is intended to be available in difficult economic times.

The skinny budget also is aimed at reducing funds that are appropriated specifically for both Hispanic-serving institutions (HSIs) and historically black colleges and universities (HBCUs). Although the proposed budget calls for “maintaining” $492 million in appropriations for HSIs and HBCUs, the current level of spending for those institutions is $577 million.

The Higher Education Act (HEA) last was reauthorized in 2008. Legislators have expressed optimism that reauthorization might occur in this session of Congress, but if history serves as any reliable guide, competing agenda items could result in delay. Republicans in both chambers are eager to prove to their base of voter support that meaningful action can be taken to repeal and replace the Affordable Care Act. Divisions within the party contributed to having such legislation grind to a halt in March 2017. Even if agreement can be reached within their own ranks, however, it is likely that differences will arise with Democrats and also between the House and Senate that can lead to further delays in producing a bill for President Trump to sign into law.

Another obstacle that can stand in the way of dealing with the Higher Education Act is the quest to reform the tax code, a major Republican campaign pledge. Even if health reform and taxes are dealt with effectively, amendments to the HEA also will contribute to delays that may not be overcome this year. Patience is a trait that must be cultivated when waiting for meaningful public policy to reach fruition.

---

2017-2018 ASSOCIATION CALENDAR OF EVENTS

**June 9, 2017**—Scholarship of Excellence Applications Deadline

**July 10-11, 2017**—Board of Directors Meeting

**September 2017**—ASAHP Election Results Announced

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

**October 10-12, 2018**—ASAHP Annual Conference in St. Petersburg, FL
AFFORDABLE CARE ACT DEVELOPMENTS

The Affordable Care Act is in its eighth year of existence. Despite repeated attempts by congressional Republicans to replace and repeal this law, it essentially remains unchanged. Nevertheless, as long as the G.O.P. has control of the House, the Senate, and the White House, a possibility exists that a replacement could become a reality. A prospect of that nature results in a great deal of uncertainty and worry not only among patients, but also throughout all sectors of the health care industry. Meanwhile, entities such as insurance companies, medical centers, and health professionals find it prudent not only to envision possible scenarios that could jeopardize their well-being, but also how to construct effective responses to whatever unfolds.

Steps That Health Organizations Can Take In A Time Of Uncertainty

A report from PricewaterhouseCoopers Health Research Institute (HRI) and the firm’s strategy practice, Strategy&, presents a comprehensive analysis of scenarios for repealing and replacing the ACA, along with practical steps health organizations can take. An analysis of three scenarios by HRI and Strategy& found that they produce dramatically different outcomes. A “repeal” scenario, once fully implemented by 2025, likely would leave an estimated 32 million more Americans uninsured than would be under the ACA. “Replace” likely would leave 12 million more Americans uninsured by 2025 than would be under the ACA. Under “repair,” the ranks of the uninsured likely would grow by six million by 2025, compared to what would be expected under the ACA. The wide range of potential outcomes for likely legislation highlights the need to model the possibilities and evaluate their consequences.

No scenario benefits all players in the U.S. health economy. The scenario with the least negative impact on the pharmaceutical and life sciences industry—“repeal”—likely would produce the most challenging outcomes for many healthcare providers and insurers. Yet, the best scenario for those stakeholders—“repair”—wouldn’t offer the same relief from ACA taxes and fees as “repeal” would for companies that make branded pharmaceuticals and nonretail medical devices. Moreover, some of these scenarios’ outcomes will depend on what has happened, and what will happen, on a state level. Healthcare providers and payers operating in states that expanded Medicaid may face more dramatic changes under “repeal” and “replace” scenarios. Some states, under a “repeal” scenario, could experience spikes in their uninsured rates of more than 100%. Similarly, the effects of proposals such as Medicaid block grants, part of the “replace” scenario, could be blunted or exacerbated depending on how states decide to handle the changes.

Selling Health Insurance Across State Lines

While on the campaign trail for the 2016 U.S. Presidential election, candidate Donald Trump often expressed his intention to repeal and replace the Affordable Care Act. One of the few specifics that he offered voters was another pledge to make health insurance available across state lines. He believed that doing so would create a truly competitive national marketplace that will reduce costs and produce far better care. The Commonwealth Fund has responded to these claims as follows.

The concept of selling insurance across state lines arose from a frustration with variation in state regulation. Proponents contend that if an insurance company were allowed to operate by the rules of just one state, but sell plans in multiple states, they could lower the price of their plans, giving consumers new and more affordable choices. While frustration with the costs of the current health care system is well-founded, proposals to allow cross-state sales will do nothing to encourage greater competition or address the underlying drivers of health care costs. Just like politics, health insurance is local. Today’s health plans essentially provide enrollees with access to a local network of doctors and hospitals at a discounted price. According to many insurance experts, the primary barrier for an insurer looking to enter a new market is not the state’s regulations, it’s the cost of building up a provider network at discounted prices. At the same time, there is a significant risk that if the ACA’s insurance reforms are repealed, and Congress enacts legislation to mandate cross-state sales, it could lead to adverse selection in many states.
DEVELOPMENTS IN HIGHER EDUCATION

An item placed on the ASAHP Newswire on April 26, 2017 should raise eyebrows at all levels of American society. It refers to a report produced by the National Student Clearinghouse Research Center regarding higher education student attainment rates by race and ethnicity. Compared to Hispanic, white, and Asian students, black students had the lowest six-year completion rate (45.9%) and among students who started in four-year public institutions, black men had the lowest completion rate (40.0%) and the highest stop-out rate (41.1%).

College completion is an absolute necessity for students who hope to become health professionals, since a great many academic programs in the health sciences require masters’ degrees and clinical doctorates to qualify for entry into practice. Moreover, as indicated in the Clearinghouse Research Center Report, the opportunity to graduate from college has important benefits to individuals and society, including job satisfaction, civic engagement, individual labor market access, and, ultimately, the nation’s economic growth and global competitiveness. Currently, inequalities in postsecondary college completion rates highlight the need for higher education leaders to design initiatives aimed at increasing participation and ameliorating racial disparities.

It is clear that inadequate graduation rates at the undergraduate level can have serious downstream consequences. For example, a lack of diversity among students in a health professions school could jeopardize an institution’s accreditation status. While some schools may have the resources to attract minority students through outreach programs and the provision of scholarships, not all institutions are that fortunate. Geographical location also can be an impediment. If a school tends primarily to attract students from a particular region in which it is situated, and that region has disproportionately fewer minority students, it becomes extremely challenging to meet enrollment goals associated with achieving diversity.

Engaging Students In Quality Assurance And Accreditation

One of the core principles of The Quality Assurance Commons for Higher and Postsecondary Education is that students should be involved in quality assurance processes at every level. Current systems in the United States only minimally involve students, typically through occasional surveys, student representation on self-study committees, or meetings with selected students during a site visit. A preliminary outreach in the fall of 2016 to a variety of students from several higher educational institutions (including community colleges, public and private colleges and universities, and graduate-level programs) via interviews and focus groups regarding quality assurance and accreditation resulted in the following central themes:

- Students lack good information about accreditation and about program or institutional quality.
- Students are deeply concerned about programs leading to employment; they have little faith that there’s a direct route or that they are being adequately prepared for future work.
- Most institutions and programs have poor feedback mechanisms for students, or if feedback mechanisms are in place, students may not know about them or feel comfortable using them.
- Students currently rely mostly on the institution or program itself for information about quality. There is no independent place for them to find verifiable information on program or institutional performance.

As a result, QA Commons has undertaken a series of initiatives to ensure students inform the organization’s work and have a central role in quality assurance.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

**Hypertension Prevalence And Control Among U.S. Adults**
According to the National Center for Health Statistics (NCHS), hypertension is a public health challenge in the United States because it directly increases the risk for cardiovascular disease. National and regional health initiatives, including Healthy People 2020, the Million Hearts Initiative, and the Community Preventive Services Task Force, have sought to increase public awareness of the health benefits of improving blood pressure control. Prevalence of hypertension among adults was 29.0% in 2011–2014 and increased with age: 18–39, 7.3%; 40–59, 32.2%; and 60 and over, 64.9%. Hypertension prevalence was higher among non-Hispanic black (41.2%) than non-Hispanic white (28.0%), non-Hispanic Asian (24.9%), or Hispanic (25.9%) adults. Prevalence of controlled hypertension was 53.0%, and adults aged 18–39 were less likely to have controlled hypertension than those aged 60 and over.

**Difficulty Of Diagnosing Rare Diseases And Discovering Cures**
About 80% of rare diseases are genetic and effective treatment exists only for a few. Most affect children. They stay in the hospital about 40% longer than everybody else, and they also generate over 50% of hospital bills. As a medical impact group, they are high up the list. The Children’s National Rare Disease Institute (CNNDI) was established this year to provide a place where researchers could work on new protocols and patients with rare diseases could find a consistent model of care. An aim is to take the diffuse field of 7,000 different rare diseases and pull it together into a clinical entity where better and more rational care can be provided. Federal grants and other incentives, beginning with the Orphan Drug Act of 1983, are designed to encourage research, treatment, and drug development for rare diseases.

**HEALTH TECHNOLOGY CORNER**

**23andMe’s Disease Risk Predictions**
After more than three years of negotiation with the U.S. Food and Drug Administration (FDA), genetic testing company 23andMe this month won the agency’s blessing to bring back some disease risk predictions. 23andMe’s saliva testing service has been limited largely to returning ancestry information and basic physical traits, because FDA in 2013 determined that the tests might pose risk to consumers who acted on less-than-definitive results without consulting a doctor. FDA ruled in 2015 that the company could return carrier status for certain genetic diseases, including cystic fibrosis. Now, the firm can tell customers whether they carry mutations associated with a greater risk of developing 10 conditions, including Parkinson’s and Alzheimer’s diseases. The new clearance is expected to expand the market for direct-to-consumer genetic tests.

**Using Virtual Reality Therapy To Treat Pain**
Virtual reality therapy is effective in significantly reducing pain for hospitalized patients, according to a new Cedars-Sinai study. In an article published online in the journal *JMIR Mental Health*, a sister publication of the *Journal of Medical Internet Research*, investigators examined 100 hospitalized patients who reported pain scores of greater than three on the Numeric Pain Rating Scale from zero to 10. Fifty patients received virtual reality therapy consisting of wearing virtual reality goggles to watch calming video content such as helicopter rides over scenic portions of Iceland, or imagery of swimming in the ocean with whales. Those patients reported a 24% drop in pain scores after using the virtual reality goggles. While it remains unknown exactly how VR works to reduce pain, the benefit is attributed to "immersive distraction," i.e., when the mind is deeply engaged in an immersive experience, it becomes difficult, if not impossible, to perceive other stimuli, including pain.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

State Policy Capacity And Leadership For Health Reform

The passage of the Affordable Care Act (ACA) initiated a flurry of decisions and activities by state health policy leaders. Implementing policy changes required in the ACA, state leaders took on issues with significant policy and operational import: Would they implement a state-based health insurance exchange? Would they expand Medicaid eligibility? How would small-group and individual insurance laws need to be changed? What definition of essential health benefits would a state adopt? A report from the Milbank Memorial Fund synthesizes lessons learned, using a combination of surveys and qualitative interviews with the personnel who did the work within the states. Key capacities are identified that are essential for good policymaking and implementation: roles, mechanisms, and leadership; staff capacity; federal resources and assistance from other sources; and outstanding needs in areas, such as ongoing policy capacity deficits. The report can be obtained at https://www.milbank.org/wp-content/uploads/2017/04/MMF_StatePolicy-Report-FINAL.pdf.

Changing Rules For Workplace Wellness Programs

Nearly all large firms (90%) that offer health benefits (“offering firms”) offer some type of wellness program, though the term “wellness program” encompasses a range of measures from health screening to more targeted health interventions. About half (47%) of all offering firms and 83% of large offering firms offered classes, coaching, or other activities to help employees stop smoking, lose weight, or adopt healthier lifestyles. An Issue Brief reviews findings from the 2016 Kaiser Family Foundation/HRET Employer Health Benefits Survey related to wellness programs and financial incentives. It also reviews findings from the 2015 National Survey on Drug Use and Health (NSDUH) related to the incidence of certain sensitive or potentially stigmatized health conditions among adults covered under employer-sponsored health plans. The report can be obtained at http://kff.org/private-insurance/issue-brief/changing-rules-for-workplace-wellness-programs-implications-for-sensitive-health-conditions/.

FDA Reports On The Voice Of The Patient

The Food and Drug Administration (FDA) has a Patient-Focused Drug Development Initiative that is a commitment under the fifth authorization of the Prescription Drug User Fee Act (PDUFA V) that aims to more systematically gather patients’ perspectives on their conditions and available therapies. As part of this commitment, FDA is holding at least 20 public meetings over the course of PDUFA V, each focused on a specific disease area. Voice of the Patient reports will summarize the information provided by patients and patient representatives at each of these public meetings. Copies of the various reports can be obtained at https://www.fda.gov/forindustry/userfees/prescriptiondruguserfee/ucm368342.htm.

How Patients And Health Professionals Arrive At Good Treatment Decisions

An answer to the question of how good treatment decisions are made can be found in a resource known as the Ottawa Decision Support Framework, which can be obtained at https://www.mainequalitycounts.org/image_upload/ODST.pdf.
INTERPROFESSIONAL PRACTICE AND EDUCATION MEASUREMENT AND ASSESSMENT

Issue 3 in the 2017 series of articles in the *Journal of Interprofessional Care* features a guest editorial by Barbara Brandt and Constance Schmitz about the National Center for Interprofessional Practice and Education. The Center was funded to provide leadership in scholarship, research, and evidence to advance the field of interprofessional education and collaborative practice as an unbiased, neutral convener. Since its inception, the measurement of team function in practice and interprofessional education has risen to an even higher priority. The National Center’s experience with the National Innovations Network and building the National Center Data Repository identified an especially acute need to find good measures of “teamwork,” as experienced by different kinds of groups working in various education and clinical environments. As a result, the National Center has supported the development of the Assessment of Clinical Environment tool and other instruments used in real time in the Nexus Innovations Network.

Since 2012, assessment of interprofessional teamwork and collaborative practice has been the number one request of the National Center. In 2014, to respond to the need for instruments, the Center created the Resource Center on its Nexus website to serve as a community exchange of assessment tools—both published and “home grown”—for local grant-funded projects and curriculum needs. The Resource Center was (and remains) an entirely community-generated, open-source platform designed to encourage sharing among members without formal peer review. Simultaneously, the Center also inaugurated a more formal, curated collection of 26 instruments, identified through literature review and networking, and screened by professional evaluators.

Mirroring the state of the field, the predominant types of tools in both the Resource Center and the Measurement Collection were self-report questionnaires regarding attitudes about (a) other professionals, (b) interprofessional learning, or (c) the concept of interprofessional teamwork/collaborative practice. Together, the combined collection also contained many surveys of individuals’ perceptions of interprofessional relationships and collaborative practices in the work place. Using the Kirkpatrick evaluation framework long recognised in the interprofessional education and collaborative practice literature, the majority of these types of tools represent Levels 1 (reaction) and 2 (attitudes /perceptions), in that they capture reactions to education efforts, attitudes believed to predispose individuals toward certain behaviors, and subjective perceptions amenable to change.

HEALTH AND INEQUALITY IN THE UNITED STATES

The British periodical *Lancet* is producing a series on health and inequality in the U.S. that focuses on how the health-care system, which could reduce income-based disparities in health, instead often exacerbates them. The life expectancy of the wealthiest Americans now exceeds that of the poorest by 10–15 years. Some key messages are as follows:

- Economic inequality in the USA has been increasing for decades and is now among the highest in developed countries.
- Despite coverage gains from the Affordable Care Act, about 27 million Americans remain uninsured—a number that is likely to increase under the reforms advocated by Republicans now empowered in Washington, DC.
- Financing of health care in the USA is regressive, with poor and middle-class individuals paying a larger share of their incomes for care than the affluent, thereby deepening inequalities in disposable income.
- Medical indebtedness is common among both insured and uninsured Americans, and often leads to bankruptcy.