UNCERTAINTY IN RELATION TO EXISTENTIALISM

Now that debates are well underway involving candidates who seek to be the Presidential nominee in the 2020 election, the word existential has been associated with a claim that climate change poses such a threat. One view of existentialism is that it represents an effort by individuals to construct meaning out of a world characterized by chaos and uncertainty. The realm of health care may be viewed as offering a suitable template for a cursory exploration of how it happens to be influenced by the term uncertainty.

Attention was drawn to this matter in a paper appearing in the October 2019 issue of the Journal of Patient Education and Counseling. The authors’ contention is that uncertainty in health care is an extremely important, but incompletely understood phenomenon. They argue that improving an understanding of the many important aspects of uncertainty in health care will require a more systematic program of research based upon shared, integrative conceptual models and active, collaborative engagement of the broader research community.

Uncertainty not only may be considered an essential facet of human life and an integral problem of health care. It is the single, common challenge faced by every patient who receives health care and every clinician who provides it, along with administrators, payers, policymakers, and researchers who deliver, finance, regulate, and study it. In every one of these diverse activities undertaken by different actors, uncertainty of one form or another—arising from various sources, pertaining to any number of relevant issues, and formed and reformed through communication—provides the call to action, and provokes a variety of different responses.

At the level of patient-provider interactions, diagnostic misclassifications and errors can result in treatment that is inappropriate and harmful. Moreover, patients may be plagued by doubts and uncertainties about their ability to remain employed, have satisfactory health insurance coverage, and be able to meet out-of-pocket costs for health care. Medicare for All proposals by political candidates raise concerns regarding whether reimbursement policies will suffice to meet the costs experienced by clinicians and facilities, such as rural hospitals. Policymakers also are faced with the quandary of coping with the task of figuring out how to provide free health care without simultaneously necessitating a huge spike in taxation.

Studies that focus explicitly on uncertainty have grown in number and diversity, but the growth is not systematic because the research has developed organically, in an uncoordinated, piecemeal fashion. Developing a more systematic approach to uncertainty in health care has the potential to improve the clinical communication of uncertainty by providing health professionals with a coherent, comprehensive understanding of the uncertainties that arise in different circumstances, the diversity of responses to these uncertainties, the various approaches to communicating uncertainty, and the many competing goals of doing so. A positive end product of enhancing this field of research could be a more comprehensive, rational, deliberate approach to communicating and managing uncertainties.
PRESIDENT’S CORNER—ASAHP MEMBER FOCUS
By Susan N. Hanrahan, ASAHP President

Time is really going way too fast!!! Our Annual Conference is right around the corner. I sure hope you are able to attend. This should be a good one.

We have continued to highlight Conference plenary speakers and other activities in our newsletters. I would like to point out that four “of our own” will be speaking at plenary sessions this year, including Dr Randy Lambrecht, who is now President of the Aurora Research Institute and System VP of Advocate Aurora Health, Dr Lisa Saladin, Provost and EVP for Academic Affairs at Medical University of South Carolina, Dr Pat Walker, Dean Emeritus at Sacred Heart University and Dr Susan Cashin who is the Director of the Office of Performance Analytics at the University of Wisconsin-Milwaukee.

Also representing one of our member institutions will be Dr Mitchell Scheiman who is the Dean of Research at Salus University who will be delivering the Switzer Lecture. Provost Lori Gonzalez of the University of Tennessee Health Science Center will be back to serve on a leadership panel entitled Recruiting Strategies and Challenges that will be held Friday morning so we will be excited to see her again. There are MANY other esteemed speakers plus all of the poster and concurrent session presentations. It will be a great time.

The Business Meeting will actually host the Association Awards this year since we are “boating” on our usual awards evening. Please plan to attend because you will get updates on a number of activities and also be able to bring new business items at the end of the meeting when we will open it up for a “town hall” discussion. Be thinking of things you might want to chat about. Phyllis King, our President Elect, will also be sharing some highlights for her two-year term as president.

The Institutional Profile Survey has gotten some new “enhancements” based on your feedback and is about ready for its second data collection release. The first aggregated data report from our new survey is ready for its “reveal” and will be appearing in the boxes of those that completed the survey. So, if you did not fill out the survey and want the data next time, please take time to fill out the IPS when it is released to our member institutions. If you have questions on this, please ask myself or Kristen in the ASAHP office.

Lastly, you have received a Bylaws notice for a name change of our association. This has been a topic of conversation over the 25 years I have been an ASAHP member. The BOD discussed this in their summer 2018 meeting and in summer 2019 made a decision to offer you a name change. We will keep the ASAHP acronym and literally replace the word “allied” with “advancing.” Since we are educating the health workforce for the 21st Century, it is a very appropriate and timely change. I hope you will vote yes.

My last note to you as President will come after the Annual Conference. See you there!!

Susan Hanrahan, President
AVOIDING A GOVERNMENT SHUTDOWN

In a typical year, legislators find it to be extremely difficult to agree on 12 appropriations bills. The current fiscal year ends on September 30. Assuming that not all of these pieces of legislation have been signed into law by that date, a remedy exists in the form of continuing resolutions (CRs). One possibility could be to produce a CR to avoid a federal government shutdown at the end of the fiscal year (FY) on September 30. Such a short-term spending bill might, for example, extend current government funding into late November or early December.

Having left Capitol Hill for most of August, elected officials returned in September with the Senate Appropriations Committee approving spending allocations for all 12 subcommittees, along with Defense and Energy and Water Development spending bills by a party line vote of 16-15. While appropriators had planned to vote on the Labor, Health and Human Services (Labor-HHS) bill and State-Foreign Operations bills, proceedings had to be postponed because of abortion-related disputes regarding Title X grant funding. Disagreements over the topic of abortion have a long history of serving as a major impediment to reaching agreement.

The 302(b) top-line spending caps for FY 2020 were decided without input from House appropriators, who already have advanced the majority of their panel’s spending bills. Labor-HHS, which includes Education, will receive $187.7 billion, a $200 million amount that constitutes only a 1% increase over FY 2019 levels.

Regardless of party affiliation, it is quite likely that continued efforts will be made to deal with the problem of high pharmaceutical prices. The soaring cost of insulin offers a stark example of exorbitant drug pricing. More than 100 million individuals are either diabetic or pre-diabetic. Although the drug was invented in 1922, its inflated-adjusted per unit price has at least tripled between the 1990s and 2014. In the U.S., insulin costs per patient have nearly doubled from 2012 to 2016 ($2,864 vs $5,075). High prices of this nature are driving up health insurance premiums and creating unaffordable costs for patients.

Proposed solutions vary between Democrats and Republicans. House Speaker Nancy Pelosi (D-CA) is preparing to issue a plan to lower drug prices by directing the U.S. Department of Health and Human Services (HHS) Secretary to negotiate the prices of the 250 drugs that are most expensive to Medicare each year and that lack competition of at least two other generic drugs, biologics, or biosimilars. Pharmaceutical manufacturers that do not negotiate or are unable to reach an agreement with the government would face a 75% penalty of the gross sales of the drug from the previous year. Other purported features include that lower drug prices would apply to both Medicare and private insurers, and that savings resulting from the lower-priced drugs would be directed to the National Institutes of Health (NIH) for the development of new drugs and treatments. The legislation also proposes a $2,000 cap on Medicare beneficiary out-of-pocket spending starting in 2022.

Meanwhile, a more moderate alternative by Republicans has emerged from the Senate Finance Committee that would require manufacturers to issue rebates to the Medicare program if prices rise faster than inflation.

2019-2020 ASSOCIATION CALENDAR OF EVENTS

October 16-18, 2019 — ASAHP Annual Conference in Charleston, SC

January 28-29, 2020 — Strategic Planning Workshop in Clearwater Beach, FL

October 26-30, 2020 — ASAHP Annual Conference in Long Beach, CA
HEALTH REFORM DEVELOPMENTS

The U.S. Census Bureau on September 10, 2019 released a report on *Health Insurance Coverage In The United States: 2018*. It revealed that in 2018, 8.5% of individuals, or 27.5 million, did not have health insurance at any point during the year. The uninsured rate and number of uninsured increased from 2017 (7.9% or 25.6 million). The percentage of beneficiaries with health insurance coverage for all or part of 2018 was 91.5%, lower than the rate in 2017 (92.1%). Between 2017 and 2018, the percentage with public coverage decreased 0.4 percentage points, and the percentage with private coverage did not statistically change. In 2018, private health insurance coverage continued to be more prevalent than public coverage, covering 67.3% of the population and 34.4% of the population, respectively. Of the subtypes of health insurance coverage, employer-based insurance remained the most common, covering 55.1% of the population for all or part of the calendar year.

Health insurance coverage is related to the highest level of education attained. Individuals with higher levels of educational attainment are more likely to have health insurance coverage than those with less education. In 2018, 96.6% of the population aged 26 to 64 with a graduate or professional degree had health insurance coverage, compared with 93.8% of the population with a bachelor’s degree, 85.1% of high school graduates, and 71.0% of the population with no high school diploma. Income is another contributing factor in coverage differences. In 2018, individuals in households with lower income had lower health insurance coverage rates than residents of households with higher income. In 2018, 86.2% of those in households with an annual income of less than $25,000 had health insurance coverage, compared with 96.8% of individuals in households with income of $150,000 or more. Inhabitants of households with lower income also had lower rates of private coverage and higher rates of public coverage. Children living in the south are more likely than children living in other parts of the nation to be without health insurance, and Hispanic children are more likely than children of other ethnicities to be uninsured.

Questions Pertaining To Enactment Of Proposed Medicare For All Legislation

Democrats competing to be the nominee by their party in the 2020 presidential election have expressed great enthusiasm for the enactment of proposed *Medicare For All* legislation. If such a law ever becomes a reality, its advantages include free coverage of benefits for all residents of the U.S. Not especially clear at this juncture, however, is how enough revenue will be generated to pay for such an expansion. Another issue worthy of consideration is how the Medicare program as it currently exists might undergo modification.

One aspect in particular is the *Medicare Advantage Program*. All baby boomers will be older than age 65 by the year 2030. Because one in every five residents will be at retirement age, Medicare enrollment can be expected to grow. By way of background, Medicare Advantage, the public-private health plan option available to Medicare beneficiaries, presently furnishes coverage for more than 22 million individuals, representing greater than one-third of all participants in Medicare. The Congressional Budget Office (CBO) estimates that current enrollment in Medical Advantage will increase to 29 million by the year 2025. A report from the Centers for Medicare & Medicaid Services in September 2018 indicates that 99% of Medicare beneficiaries have access to at least one Medicare Advantage Plan. The firm Avalere Health estimates that Medicare Advantage beneficiaries have higher rates of clinical and social risk factors than Traditional Medicare beneficiaries: 64% are more likely to be enrolled in Medicare due to disability, 57% have a higher rate of mental illness, and 16% have higher rates of alcohol/drug/substance abuse.

Assuming that existing Medicare is unaffected by the outcome of the 2020 election, as more beneficiaries switch from Traditional Medicare into Medicare Advantage, plans can be expected to become an increasingly important driver of a quest for high-quality care. If Medicare For All becomes a reality instead, whether private insurance coverage will continue to exist remains an open question. If so, plans, providers, community partners, beneficiaries, and policymakers are going to have to cooperate in figuring out how to support current efforts and build new opportunities to improve beneficiary health and quality of life.
DEVELOPMENTS IN HIGHER EDUCATION

What transpires in the nation’s capital can have dramatic effects on higher education institutions. An example is the amount of federal funding that is directed to these entities annually. A segment of higher education that is in the spotlight as the government’s current fiscal year ends at the close of September 2019 consists of historically black colleges and other minority-serving institutions. Passed by the U.S. House of Representatives, H.R. 2486 must be taken into consideration by the Senate. The purpose of this legislation is to reauthorize $255 million of mandatory funding each year for programs under Title III of the Higher Education Act, which provides grants to historically black colleges and other institutions that enroll a large share of minority students.

These programs also receive discretionary funding from Congress each year, but the mandatory add-on funding expires on September 30. Officials at the Department of Education have indicated that there are plans to carry over unused mandatory funds from the current fiscal year into future years, so that many existing grants would remain in effect regardless of whether the funding stream expires.

Finalizing Stricter Rules For Student Loan Fraud Claims
An overhaul of rules known as “borrower defense to repayment” is in the process of being officially finalized this month. The purpose of the new policy is to set a more stringent standard for when the government will eliminate the debt of borrowers who claim they were misled or deceived by their institution. A notable example occurred during the Obama Administration when rules were written following the collapse of the for-profit college company Corinthian Colleges in 2015, which resulted in tens of thousands of former students sending requests to the Department of Education for loan forgiveness. Currently, the backlog of existing "borrower defense" claims exceeds 170,000 applications, but the Department has not taken any action on these claims in more than one year.

Education Department Secretary Betsy DeVos has stated that fraud in higher education will not be tolerated by the Trump Administration, adding that the final rules include carefully crafted reforms that hold colleges and universities accountable, and treat students and taxpayers fairly. An expectation is that these newer more strict standards will result in the Department approving fewer borrower defense claims, thereby reducing the amount of loan forgiveness by an estimated $512 million per year. The entire package of regulations, which also curtails loan discharges for students whose schools suddenly close, is projected to save taxpayers more than $11 billion over the next decade.

The new rules are designed to allow borrowers to have their loans forgiven if they can show their institution in a misrepresentation, but they must prove additional elements demonstrating that they relied on the college's misrepresentation and also must document financial harm more extensively. Another major change is a requirement that borrowers apply for loan forgiveness within three years of leaving school. Opponents of the rules are expected to mount legal challenges.

Trends In Ratio Of The Pell Grant To Total Price Of Attendance And Federal Loan Receipt
A new Data Point issued in August 2019 by the U.S. Department of Education is based on figures from four iterations of the National Postsecondary Student Aid Study (NPSAS), a large, nationally representative sample survey of students that focuses on how they finance their postsecondary education. An emphasis is on the percentage of total price of attendance covered by Pell Grants and the percentage of Pell Grant recipients who received federal student loans for academic years 2003–04, 2007–08, 2011–12, and 2015–16. Overall, the percentage of total price of attendance (tuition and fees, plus the cost of room and board, books and supplies, transportation, and personal expenses) covered by Pell Grants has remained consistent for selected years between 2003–04 and 2015–16, with the exception of 2007–08. The percentage of total price of attendance covered by Pell Grants was lower in 2007–08 (20%) compared to the 24% covered in all other years (2003–04, 2011–12, and 2015–16). These grants covered more of the total price of attendance for students at public 2-year institutions compared to public 4-year institutions, private nonprofit 4-year institutions, and private for-profit institutions in all selected academic years between 2003–04 and 2015–16.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Mortality Patterns Between States With Highest Death Rates And States With Lowest Death Rates

A Data Brief from the National Center for Health Statistics (NCHS) in September 2019 indicates that the average age-adjusted death rate for the five states (AL, KY, MS, OK, WV) with the highest rates (926.8 per 100,000 standard population) was 49% higher than the rate for the five states (CA, CT, HI, MN, NY) with the lowest rates (624.0). Age-specific death rates for all age groups were higher for the states with the highest rates compared with the states with the lowest rates. Age-adjusted death rates were higher for non-Hispanic white and non-Hispanic black populations, but lower for the Hispanic population in states with the highest rates than in states with the lowest rates. The age-adjusted death rates for chronic lower respiratory diseases and unintentional injuries for the states with the highest rates (62.0 and 65.5, respectively) were almost doubled compared with the states with the lowest rates (31.0 and 35.8).

Comparing Retail Clinics With Other Sites Of Care

According to an article published in the September 2019 issue of the journal Medical Care, with primary care transforming from care delivered exclusively in a physician's office to care that can be delivered in multiple sites and through different means, such as virtually and in retail settings, it is important to critique what is being gained from this primary care transformation and what, if anything, is being lost. For instance, entrepreneurs, policymakers, and officials at pharmacy and hospital chains may believe that the retail clinic model of primary care should include complex service delivery. Yet, the current body of research does not furnish enough information about whether this belief is founded in reality. As long as much of what is known for evaluating retail clinic care involves proprietary data controlled by advocates of retail clinics, uses more simplistic assessments of cost and quality, and leaves out the patient experience, there remains much that is unknown about this type of primary care.

HEALTH TECHNOLOGY CORNER

The Use of Small-Scale, Soft Continuum Robots To Navigate In Cerebrovascular Areas

An article published on August 28, 2019 in the journal Science Robotics describes the development by Massachusetts Institute of Technology engineers of a magnetically steerable, thread-like robot that actively can glide through narrow, winding pathways, such as the labyrinthine vasculature of the brain. In the future, this robotic thread may be paired with existing endovascular technologies, making it possible to guide the robot remotely through a patient's brain vessels to treat blockages and lesions quickly, such as those that occur in aneurysms and stroke. The latter is the number five cause of death and a leading cause of disability in the United States. If acute stroke can be treated within the first 90 minutes or so, researchers believe that patients' survival rates could increase significantly. A hope is that designing a device to reverse blood vessel blockage within a so-called “golden hour” potentially could result in the avoidance of permanent brain damage.

The Use Of “Phyjamas” In Health Care

The Ubicomp 2019 Conference on September 11-13, 2019 in London featured a presentation by researchers at the University of Massachusetts, Amherst who developed physiological-sensing textiles that can be woven or stitched into sleep garments they have dubbed "phyjamas." They designed a new fabric-based pressure sensor and combined that with a triboelectric sensor, one activated by a change in physical contact, to develop a distributed sensor suite that could be integrated into loose-fitting clothing like pajamas. They also developed data analytics to fuse signals from many points that took into account the quality of the signal arriving from each location. They report that this combination allowed them to detect physiological signals across many different postures. By performing multiple user studies in both controlled and natural settings, they showed that they can extract heartbeat peaks with high accuracy, breathing rate with less than one beat per minute error, and predict sleep posture perfectly.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Hospital Concentration Index

A small number of hospitals in many U.S. metro areas increasingly are seeing most of the country’s hospital admissions. Some 67% of U.S. metro areas, 75 cities and towns, had high concentrations of hospitals in 2012, but those figures increased by 2016. That year, some 81 metro areas had high concentrations of health care facilities. Rural areas tended to have more patients who sought their care from only a few hospitals. Health care spending in the United States is increasing and accounts for nearly 18% of U.S. economic activity. According to a new report from the Health Care Cost Institute, while policymakers continue to explore the contributors to this phenomenon at the national level, differing local trends add complexity, but critical detail, to the picture of how health care dollars are spent across the country. Investigators analyzed more than 1.8 billion health care claims for individuals with commercial insurance from 2012 to 2016. They computed measures of health care service prices and use, and other measures such as provider market structure for 112 local areas in 43 states. They found that not only did spending trends and drivers vary substantially across metro areas, they varied within metro areas when data were segmented into categories like inpatient, outpatient, and physician services. In summary, each metro had a different experience. The report can be obtained at https://www.healthcostinstitute.org/research/hmi/hmi-interactive?utm_source=STAT+Newsletters&utm_campaign=f2663a3734-MR_COPY_01&utm_medium=email&utm_term=0_8cab1d7961-f2663a3734-149940042.

Reducing Inequities In Healthy Life Expectancy

A September 2019 brief from the Urban Institute is one of an eight-part Catalyst series indicating what it would take to advance bold solutions over the next 50 years. Across the country, health care providers and public, private, and nonprofit payers are exploring solutions to help individuals meet their health-related social needs, particularly among Medicaid enrollees. Along the way, they are generating new insights and raising critical questions about what works. The brief highlights five bold approaches that could narrow inequities in health outcomes and healthy life: (1) Assess health-related social needs, (2) Build community resource networks, (3) Incentivize investments in non-medical services with health payoffs, (4) Provide sustainable financing, and (5) Align organizational policies and activities. Based on conversations with innovative thinkers and doers, three areas also were identified where today’s health care payers, plans, and providers need new data and analysis to accelerate promising solutions for improving health equity by better addressing individuals’ health-related social needs. They are: (1) Identify high-priority social needs, (2) Build an actionable evidence base of proven interventions, and (3) Assess strategies for integrating health, social services, and other systems. The brief can be obtained at https://next50.urban.org/sites/default/files/2019-09/Next50%20Health%20Catalyst%20Brief_0.pdf.

Investing In Interventions That Address Non-Medical, Health-Related Social Needs

On April 26, 2019, the Board on Population Health and Public Health Practice of the National Academies of Science, Engineering, and Medicine held a public workshop to explore the potential effects of addressing non-medical, health-related social needs on improving population health and reducing health care spending in a value-driven health care delivery system. The presentations and discussions highlighted in this Proceedings of a Workshop provide a general discussion of the issues, trends, and the opportunities and challenges of investing in interventions that address patients’ non-medical, health-related social needs. The Proceedings can be obtained at https://www.nap.edu/read/25544/chapter/1#iv.
BALEFUL IMPACT OF WORKPLACE INCIVILITY ON HEALTH

The political realm has long served as a venue for conflict among individuals and groups with widely different opinions on important public policy issues. A new study indicates that the worksite is not immune to the expression of opposing points of view. As noted in the results of a study published in the August 2019 issue of the journal *Stress & Health*, the workplace is an environment where individuals have little choice about with whom they interact. As such, employees may find themselves engaged in conversations with co-workers whose political opinions and perspectives are divergent from their own. The investigation examined how co-workers' dissimilarity in political identity is related to the quality of their interpersonal interactions and subsequent well-being. The authors predicted that political identity dissimilarity is associated with experiences of workplace incivility and, in turn, declines in psychological and occupational well-being. Hypotheses were tested in a four-wave survey study conducted during the 2012 U.S. presidential election. The results indicated that political identity dissimilarity was associated with increased reports of incivility experiences instigated by co-workers, which in turn, was associated with increased burnout and turnover intentions and diminished job satisfaction. Several practical implications for organizations are offered in the manuscript.

“BURNOUT” AND EARLIER SOMATIC PHENOMENA

Professional health literature is replete with examples of how clinicians are adversely affected by burnout, a term applied to a variety of imprecise symptoms associated with the onset of conditions involving stress, fatigue, and depression. A question worth pondering is whether burnout is the equivalent terminologically of old wine in a new bottle? A paper appearing in the September 2019 issue of the periodical *The Journal of Nervous and Mental Disease* rephrases the questions as follows: Is today's 21st century burnout an earlier century's neurasthenia? Viewed in this light, the author advances a proposition that "stress" of all kinds (itself a fuzzy concept), including overwork, discouragement, disillusionment, demoralization, and even suicide, have been known as an accompaniment of training and practice for decades. Is something catastrophic happening or are practitioners merely being swept along in a profound, but ill-defined contagious tide of discontent? Is burnout merely this era's zeitgeist, the remnant of "compassion fatigue" of "wounded warriors" of years past, or neurasthenia of the 1900s? In an effort to conclude on a positive note, an observation is made that hysteria, neurasthenia, hypochondriasis, and other conditions all have had their day and cultish followers. With better definition of the problem(s) comes more effective interventions. The author considers the possibility that burnout most likely will experience the same historical reality of earlier variants.

THE ROLE OF ACCIDENTS ON THE PATHWAY TO INJURY AND DEATH

As the third leading cause of death in the U.S., accidents involve all age groups. Adoption of prevention measures has enormous potential to avoid such outcomes, but producing an accident-free environment continues to be a major uphill struggle. Motor vehicle crashes are the leading cause of injury and death for adolescents in this country. A possible developmental source of crash risk is working memory (WM). Results of a study published on September 13, 2019 in *JAMA Network Open* suggest that a relatively slower WM growth trajectory is associated with young driver crashes. Routine assessment of WM across adolescence may help to identify opportunities for providing adaptive interventions. Meanwhile, a correspondent who occasionally provides information proved useful for inclusion among views expressed in ASAHP’s newsletter TRENDS confessed earlier this month to incurring a severe wound by attempting to remove an avocado pit with a knife. The injury occurs frequently enough that it is referred to as “avocado hand,” a condition that results in making a dash to an emergency room for treatment. More precisely, the expression “post-brunch surge” of avocado-related injuries is being used to describe hand wounds sustained on Saturdays. A suggested remedy is to post safety labels on this fruit.