COSTS ASSOCIATED WITH NONADHERENCE

Patients with physical and mental health ailments seek relief through interactions with a wide range of health care practitioners. Assuming that accurate diagnoses are made and effective forms of affordable treatment are available, then prescribing remedial and curative interventions should produce desired outcomes. A major problem is that some patients fail to adhere to recommendations and the result is the occurrence of highly significant kinds of costs that affect not only them as individuals, but also their caregivers and society as a whole.

An ongoing concern is the high cost of health care and what can be done to pay for it. According to the March 2019 issue of the journal *Medical Care*, medication nonadherence for diabetes, heart failure, hyperlipidemia, and hypertension resulted in billions of Medicare fee-for-service expenditures, millions in hospital days, and thousands of emergency department visits that could have been avoided. If the 25% of beneficiaries with hypertension who were nonadherent became adherent, it is estimated Medicare could save $13.7 billion annually, with over 100,000 emergency department visits and seven million inpatient hospital days averted.

Patients and health professionals enter into a transaction at the point of care in which both sides are in a position to gain or lose in various ways. Clinicians benefit from the opportunity to practice their knowledge and skills while simultaneously being able to obtain a livelihood through payment for services rendered. The health status of recipients of care may improve by symptom reduction, pain relief, and contributions to enhancing overall wellbeing.

Both sides of the equation must function in responsible ways for outcomes to be of optimal worth. Caregivers need to go beyond the provision of hands-on care by educating patients about the purpose of an intervention and ascertaining that these individuals fully understand their personal roles in taking medications properly, following dietary recommendations, and achieving satisfactory levels of physical fitness. Many aspects of care are volitional on the part of patients. Whereas being treated with hot packs or receiving a massage tend not to require much active patient involvement, a considerable amount of health care entails patient consent from the perspective of their needing to know why certain procedures are warranted. These individuals also must demonstrate both resilience and a willingness to cooperate in what is being furnished.

Some patients may lack adherence because of the unaffordability of medications, but other factors, such as low health literacy may be more pertinent. It is common today for patients to receive telephone and text messages reminding them of an upcoming appointment with a health professional, but less seldom are messages aimed at determining follow-up levels of patient understanding and adherence to recommended protocols. Although it is relatively easy and comforting for practitioners to assume that adherence occurs, the truth may be otherwise. As a potential downside, it is worth noting that a failure by nonadherent patients to show improvement can result in increased dissatisfaction on the part of caregivers that possibly contributes to feelings of burnout, a major issue in health care today.
In my message in the November 2017 issue, I indicated that I will be asking some of you to send a photo and answer a series of “fun” questions to be shared with our membership so that we can continue our collegiality through our newsletter. The 11th of many profiles and the third in 2019 is presented as follows:

Name and Title: Curt Lox, Dean, Brooks College of Health  
Place of birth: Harbor City, CA  
University: University of North Florida  
How long have you been in your position? Almost two years  
What’s the value of a university education? Socioeconomic mobility, psychosocial development  
What is the value of ASAHP? ASAHP brings together dedicated individuals who are all focused on health, broadly defined. Whenever a group of passionate, educated professionals congregate, great things can happen.  
Your philosophy on education in seven words: Engaging, expanding, and challenging young minds (OK, that is only six words but perhaps I can get extra credit for efficiency?)  
If I could teach in another field, which one and why? I enjoy talking about leadership so that would probably be my choice though I have no formal training in this area.  
Before I retire I want to: See my unit become a nationally-recognized College of Health  
What music is playing in my car/office? I will forever be a big fan of music from the 80’s.  
The last book I read for fun was: The latest Lee Child (Jack Reacher) novel  
My favorite trip was: Mediterranean cruise  
If I could travel anywhere it would be: Australia/New Zealand  
Four people I’d take to coffee or have a glass of wine with: There is much more I wish I knew about my family history so my first two selections would be my grandfather and grandmother (both deceased). As a Beatles fan, I’d love to visit with Paul McCartney. As a sports fan and student of leadership, I would have welcomed the opportunity to pick John Wooden’s brain if he were still with us.  
The best advice I ever received was: From my dad. He said that it was critical to work hard in school so that I could find a job that I loved because it would occupy a large portion of my life. I’m glad I took his advice because I love what I do.  
My hobby is: Outdoor activities and travel  
My passion is: People (we’re social beings!)  
A perfect day is: Exploring a geographical region I’ve never been before with family and/or friends.  
Cats or dogs? Definitely dogs  
E-book or hardback? Hardback  
Beach or mountains? I love them both but given that I live three miles from the beach, I’d have to say the former.  
I wish I could: Play a musical instrument  
My favorite saying is: From former Notre Dame football coach Lou Holtz: “The only things that are going to change you from where you are today to where you are going to be five years from now are the people you meet and the books you read.”
FEDERAL BUDGET RELEASE AND PROPOSED LEGISLATION

The Trump Administration released its FY 2020 Federal Budget proposal on March 11. During the week of March 17, additional materials were released, including an appendix, analytical perspectives, and a Major Savings And Reforms Document that contains detailed information for use by the Appropriations Committees. An overall view reveals proposed savings of $48.4 billion in discretionary programs, including $25.8 billion in program eliminations and $22.6 billion in reductions. If history is any guide, legislators are unlikely to accept what the Administration has offered and will weigh in regarding what they consider to be more alternative ways of allocating federal dollars.

Immediate Congressional criticism of the Administration budget has focused on spending reductions on health programs that are considered too harsh. For example, the President’s proposal would cut hundreds of billions of dollars from Medicare. The budget also would slash funds for the National Institutes of Health by $5.5 billion in 2020, including a $897 million reduction in the National Cancer Institute's budget. The Administration also wants to provide $256 million to consolidate the Agency for Healthcare Research and Quality's work into the National Institute for Research in Safety and Quality, which is part of an attempt to streamline federal research.

Prior to taking action to pass 12 annual appropriations bills, lawmakers first will have to reach an agreement to raise spending caps under the Budget Control Act (BCA) so that appropriators have top-line spending limits with which to work. Absent a new agreement, discretionary spending caps will be cut to the levels outlined in the BCA for FY 2020, approximately $126 billion less than FY 2019.

Regarding other legislation, Senators Ron Wyden (D-OR), Marco Rubio (R-FL), and Mark Warner (D-VA) on March 6, 2019 reintroduced the Student Right to Know Before You Go Act (S. 681) to provide information through the U.S. Department of Education (USDE) on the costs and outcomes associated with higher education. Data focusing on graduation rates, debt levels, and earnings would be generated based on student information from institutions, along with loan and income information from USDE and the Internal Revenue Service. Versions of this bill have been introduced in every Congress since 2012. A companion bill (H.R. 1565) was introduced in the House by Duncan Hunter (R-CA).

Senators Bill Cassidy (R-LA), Elizabeth Warren (D-MA), and 13 other Republicans and Democrats reintroduced the College Transparency Act (S. 800) on March 14, 2018. Initially introduced in the previous Congress, the bill would change the way the USDE collects information on postsecondary institutions, modifying the college reporting system to include student outcomes information, such as completion and post-college employment. Institutions would provide data for USDE to generate post-college outcome reports to be presented on a user-friendly Website. Currently, the Higher Education Act (HEA) prohibits a student unit record system. A companion bill (H.R. 1766) was introduced in the House by Mitchell Paul (R-MI).

A Medicare For All Act also was introduced in this session of Congress and will be discussed on the next page of the current newsletter.

2019-2020 ASSOCIATION CALENDAR OF EVENTS

April 1, 2019—Deadline for Submitting Institutional Profile Survey Data

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

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

The 1st Session of the 116th Congress featured the introduction of the Medicare For All Act Of 2019 (H.R. 1384) in the House of Representatives by Pramila Jayapal (D-WA). The bill had 107 Democrat co-sponsors. It calls for transforming the Medicare program into a single payer system that would be implemented over a two-year period beginning after the bill is signed into law. Beneficiaries could keep their current health insurance coverage during the two-year transition period, but would lose it once the Medicare plan began. Individuals automatically would be enrolled in the program at the time of birth in the U.S. Coverage would include inpatient and outpatient hospital care; ambulatory services; primary and preventive care (also chronic care); prescription drugs; biologics; medical devices; mental health and substance abuse treatment services; laboratory and diagnostic services; maternity care; dental and vision care; and long-term care. Health plans and employers still could provide additional benefits not covered by the Act. No co-payments, premiums, deductibles, or similar charges would be imposed.

It cannot be expected that a piece of legislation this broad will be passed and enacted anytime soon. Many vested interests stand to be affected quite dramatically. They include: providers, insurance companies, pharmaceutical firms, medical device manufacturers, and individuals who are satisfied with their present coverage. Figuring out how to pay for benefits is another challenging aspect that has serious ramifications for the nation’s tax structure.

The Medical Device Tax As A Means Of Offsetting Health Care Costs
When the Patient Protection and Affordable Care Act (ACA) became law nine years ago this month, it was anticipated that new taxes would help to offset some of its costs. One example is a medical device tax. This 2.3% federal excise levy on the medical device industry has been suspended and delayed since the law was enacted. More recently, the tax was delayed retroactively and will not go into effect until January 1, 2020. Senators Pat Toomey (R-PA) and Amy Klobuchar (D-MN) have introduced legislation (S. 692) to repeal this tax permanently. The bill currently has 25 bipartisan cosponsors.

A Bipartisan Approach To Reducing Health Care Cost Growth
Barring any overnight developments that produce cures for major causes of mortality, such as heart disease and cancer, due to a steady growth in the overall population of the U.S. and accelerating increases in the number and proportion of the aged, health care costs will continue to increase. Recent years have witnessed considerable amounts of dissention and polarization in the political arena. Thus, it always is refreshing whenever spurts of bipartisanship occur. On March 1, eight prominent health economists from the Brookings Institution and the American Enterprise Institute, organizations seldom aligned ideologically, sent Lamar Alexander (R-TN), Chairman of the Senate Committee on Health, Education, Labor, and Pensions (HELP), a list of 13 recommendations for the government to reduce the growth in health care costs. Recommendations include: passing legislation to expand mandatory bundled-payment programs and to end surprise out-of-network billing; and increasing Medicare payments for primary-care services and reducing them for other services.

Curtailing Fraud In Government Health Programs
Every year, billions of dollars in outlays and government program complexity combine to result in a susceptibility to improper payments, including fraud. Although there are no reliable estimates of fraud in Medicare, in fiscal year 2017 improper payments were estimated at about $52 billion, according to the Government Accountability Office (GAO). On February 25 of this year, the House passed H.R. 525, the Health Care Fraud Prevention Task Force Act, by voice vote. The bill would create the Health Care Fraud Prevention Task Force, a public-private partnership that would identify nationwide health care waste, fraud, and abuse and would supersede the Health Care Fraud Prevention Partnership (HFPP), which currently is operated by the Centers for Medicare & Medicaid Services (CMS). The newly established task force would contract with a third party to detect and prevent health care fraud through information sharing; streamline analytical tools and data; and provide a forum for government and industry experts to exchange successful anti-fraud practices. The task force also would be required to submit a report every two years to Congress showing any progress and cost savings attributable to the partnership.
The month of March 2019 was characterized by a considerable amount of activity on Capitol Hill and by the Trump Administration involving the topic of higher education. Regarding the latter, mention was made on page three of this issue of the newsletter about President Trump’s introduction of a federal budget proposal for FY 2020, which begins on October 1 of this year. Apart from proposed spending reductions in key health programs and activities, his budget includes a cut for the Department of Education, a streamlined repayment process for student loans, and the elimination of the Public Service Loan Forgiveness program. The Department’s reduction would be about $8.5 billion or 12%, including a cancellation of surplus funds in the Pell Grant program. Whether any of these proposed changes ever see the light of day will require the approval of Congress, which does not seem highly likely.

The Congressional arena had its own highlights with hearings on reauthorizing the Higher Education Act (HEA). Last renewed in 2008, this legislation authorizes various programs within the Department of Education, including the federal aid programs that support students wanting to pursue a postsecondary education. The House Committee on Education and Labor conducted the first of five scheduled bipartisan HEA hearings on the topic, “The Cost of College: Student Centered Reforms To Bring Higher Education Within Reach” and the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on “Reauthorizing The Higher Education Act: Simplifying The FAFSA And Reducing The Burden Of Verification.” Both events were covered thoroughly by ASAHP staff. Comprehensive summaries were placed on the Association’s NEWSWIRE on March 12 (Senate Hearing) and March 14 (House Hearing). These items then were distributed to the membership on March 15.

Meanwhile, a set of proposals from the White House was released on how to reform the HEA through legislation and revise higher education regulations. The list calls for the accreditation process to focus on student outcomes, asserting that current compliance-focused federal requirements inhibit innovation and that accrediting organizations need to return to the primary purpose of ensuring educational quality. Congress is requested to streamline the 10 federal recognition standards to focus on educational quality and student learning. The proposals also call for defining accrediting organizations by the mission of their institutions, rather than geographically, as regional accreditors currently are structured.

Department Of Education Negotiated Rulemaking
The Department of Education (USDE) held the second of four sessions of its negotiated rulemaking (a process to reach agreement on the terms of a proposed administrative rule or regulatory change) on accreditation and other topics on February 19-22, 2019 in Washington, DC. The first session was on January 14-16, 2019, the third one is scheduled for March 25-28, 2019, and the fourth on April 1-3, 2019. A main committee focuses on accreditation while three subcommittees address distance learning and educational innovation, faith-based entities’ participation in Title IV programs, and TEACH Grants. At the February session, the committee received reports from the subcommittees, responded to questions posed by the Department, and addressed several proposed regulations, including: permitting accrediting organizations to waive certain criteria for institutions to encourage innovation, transferring credit among institutions, and limiting the number of states in which a regional accrediting organization could operate.

Borrower Defense to Repayment Regulations
On November 1, 2016, the Department of Education published final regulations concerning borrower defense to repayment and other related matters in the Federal Register. The original effective date (July 1, 2017) of these regulations was delayed by the Department, but by order of the U.S. District Court for the District of Columbia, the 2016 final regulations from the Obama Administration must take effect. They govern loan forgiveness for defrauded borrowers, ban some types of mandatory arbitration agreements, give federal officials new tools to go after troubled colleges, and require for-profit colleges to warn students if alumni have low loan repayment rates. The current Administration now must implement them.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Selected Estimates Based On National Health Interview Survey, January To September 2018
Some results for the period January to September 2018 are: (1) the percentage of persons who had a usual place to go for medical care was 87.7%, which was lower than, but not significantly different from, the 2017 estimate of 88.3%; (2) the percentage of the population that failed to obtain needed medical care due to cost at some time during the past 12 months was 4.7%, which was not significantly different from the 2017 estimate of 4.5%; (3) the prevalence of obesity among U.S. adults aged 20 and over was 31.7%, which was not significantly different from the 2017 estimate of 31.3%; (4) the percentage of persons who had excellent or very good health was 66.3%, which was not significantly different from the 2017 estimate of 66.4%; and (5) the percentage of adults aged 65 and over who needed help with personal care from other persons was 7.0%, which was not significantly different from the 2017 estimate of 6.7%.

Electronic Health Behaviors Among U.S. Adults With Chronic Disease
As reported on March 3, 2019 in the Journal of Medical Internet Research, a study explored (1) the differences in technology use; (2) Web-based health information seeking and use behaviors; (3) attitudes toward seeking health information on the Web; and (4) the level of eHealth literacy between adults aged 18 and 64 years with and without chronic disease. About one in three (37.2%) participants reported at least one chronic disease diagnosis. Seventy-five percent of all participants reported having ever searched for health information on the Web. Participants with a chronic disease reported significantly higher instances of visiting and talking to a health care provider based on health information found on the Web (40.0% vs 25.8% and 43.3% vs 27.9%). The uses of health information found on the Web also significantly differed between participants with and without chronic diseases in affecting a decision about how to treat an illness or condition (49.2% vs 35.0%), changing the way they cope with a chronic condition or manage pain.

HEALTH TECHNOLOGY CORNER

Use Of Toilet Seats To Detect Chronic Heart Failure
A paper published on January 18, 2019 in JMIR mHealth and uHealth indicates that a toilet seat–based cardiovascular monitoring system with an integrated electrocardiogram, ballistocardiogram, and photoplethysmogram developed by a Rochester Institute of Technology team is capable of clinical-grade measurements of systolic and diastolic blood pressure, stroke volume, and peripheral blood oxygenation. Toilet seat–based estimates of blood pressure and peripheral blood oxygenation were compared to a hospital-grade vital signs monitor. This system could be positioned uniquely to capture trend data in the home that previously has been unattainable. Demonstration of the clinical benefit of the technology requires additional algorithm development and future clinical trials. With one million new cases of congestive heart failure diagnosed each year, if the FDA eventually approves the product, it could make it easier for hospitals to monitor patients with this condition in the comfort of their own homes.

Medical And Health Data Wearable
OneLife Technologies Corp., a mobile medical software/data collection company, offers the first AT&T LTE-M certified medical wearable. The OnePulse smartwatch goes beyond tracking steps by providing activity trackers, reminders, and alert technologies. Powered by AT&T wireless connectivity, the advanced wearable securely and independently transmits certain critical medical and health data to the cloud, allowing clinicians, patients, and their caregivers to monitor user status and well-being. The AT&T LTE-M connection allows clinicians near real-time access to patient data in a highly secure environment, offering caregivers the ability to intervene when necessary. The OnePulse technology provides data at the wrist for heart rate, location, movement, and sleep. OneLife’s proprietary Bluetooth protocol also has the ability to connect easily to other health and medical devices, e.g., blood pressure cuff, glucometer, and a weight scale.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Emerging Technologies To Support An Aging Population

Emerging technologies that have significant promise to improve quality of life for all Americans, particularly those with physical or cognitive burdens due to aging or disability, are identified in a new report from the White House Task Force on Research and Development for Technology to Support Aging Adults. The report, Emerging Technologies to Support an Aging Population, highlights innovations with the potential to improve quality of life, enhance individual choice, reduce caregiver stress, reduce cut healthcare costs. Research and development needs also are identified. The report outlines six areas in which technology has the potential to improve the lives of aging adults: key activities of independent living; cognition; communication and social connectivity; personal mobility; transportation; and access to healthcare. The report can be obtained at https://www.whitehouse.gov/wp-content/uploads/2019/03/Emerging-Tech-to-Support-Aging-2019.pdf.

School Success: An Opportunity For Population Health

The National Academies of Sciences, Engineering, and Medicine’s Roundtable on Population Health Improvement hosted a workshop in Oakland, California, at the California Endowment’s Oakland Conference Center on June 14, 2018. The workshop featured presentations that described the relationship between the health and education sectors and shared examples of public health interventions and activities in schools that support school success and are potential opportunities for population health action. The day began with two keynote presentations reflecting on how educational attainment influences health outcomes and how health status affects educational performance. Keynote speakers were followed by Ted Talk style presentations describing school-based public health interventions and the workshop concluded by addressing policies, issues, and opportunities pertaining to shared measurement, legal issues, payment mechanisms, and equity. Steven Woolf from the Center on Society and Health at Virginia Commonwealth University articulated why educational success matters for health. He stated that although the health and education systems work toward similar ends, they have functioned as silos for many years without much communication. Woolf presented an overview of what shapes health through five domains: (1) health systems, (2) individual behaviors, (3) the physical and social environment, (4) public policies and spending, and (5) socioeconomic factors. The public policy and spending domain is of specific importance given that it drives the other domains. Proceedings of the workshop can be obtained at https://www.nap.edu/read/25370/chapter/1.

CARE Act Implementation: Progress And Promise

The AARP Public Policy Institute published a Spotlight report, The CARE Act Implementation: Progress and Promise. The Caregiver Advise, Record, Enable (CARE) Act became law in 40 states and territories in just four years, while additional states have initiated the legislative process. The swift uptake indicates policy maker recognition of the support family caregivers need to perform the medical/nursing tasks they face at home after a family member or friend is discharged from the hospital. The landmark 2012 AARP and United Hospital Fund report Home Alone: Family Caregivers Providing Complex Chronic Care, funded by The John A. Hartford Foundation, drove the rapid policy adoption of the CARE Act. The report also inspired the creation of the Home Alone AllianceSM, a partnership of public, private, and nonprofit organizations coming together to change the way health care organizations and professionals interface with family caregivers. This Spotlight provides an update on CARE Act implementation, bringing in views from the field. The report can be obtained at https://www.aarp.org/content/dam/aarp/ppi/2019/03/the-care-act-implementation-progress-and-promise.pdf.
IMPACT OF MARIJUANA LAWS ON HEALTH AND LABOR SUPPLY

As the proportion of the older segment of the population continues to increase both numerically and proportionately, a useful exercise might be to examine how various laws affect them. For example, given the increased popularity of state legislation to legalize the use of marijuana for medical purposes (now legal in 33 states and the District of Columbia) and also for recreational purposes (currently legal in 10 states and DC), use of that substance can be assessed from the standpoint of health and the labor supply for older individuals. A step in that direction is represented by the results of a study reported in the Journal of Policy Analysis and Management on February 6, 2019. Investigators quantified the effects of state medical marijuana laws (MML) on the health and labor supply of adults age 51 and older, focusing on the 55% with one or more medical conditions with symptoms that may respond to medical marijuana. Three principle findings emerged from the analysis. First, active state MMLs lead to lower pain and better self-assessed health among older adults, including a 3.4% increase in the probability of reporting very good or excellent health. Second, state MMLs lead to increases in older adult labor supply, with effects concentrated on the intensive margin, with post-MML full-time employment increasing by 5%. Third, the effects of MMLs are largest among older adults with a health condition that would qualify for legal medical marijuana use under current state laws. These findings highlight the role of health policy in supporting work among older adults and the importance of including them in assessments of state medical marijuana laws. Age patterns of disease suggest that the health benefits of MML passage could be concentrated among older adults. The authors contend that if the implementation of an MML, by promoting access to marijuana for medical use, reduces symptoms associated with work-impeding health conditions, then MMLs could enhance labor supply among the fastest growing segment of the population. This policy effect could facilitate greater retirement savings and also potentially delay the initiation of Social Security benefit claims.

GLOBAL SYNDEMIC OF OBESITY, UNDERNUTRITION, AND CLIMATE CHANGE

A syndemic is a portmanteau term, constituting a style of writing often employed by James Joyce in Finnegans Wake and Lewis Carroll in Through The Looking-Glass, to denote a fusion between the words synergy and epidemic. The 23 February-1 March 2019 issue of the British journal The Lancet furnished readers with an opportunity to obtain an enhanced understanding of how obesity, undernutrition, and climate change affect most inhabitants of every nation and region worldwide. A proposition is advanced that the entities do so by co-occurring in time and place; interacting with each other to produce complex sequelae; sharing common underlying societal drivers; and representing three of the gravest threats to human health and survival. One form of purported multifold damage linking the problematic threesome is agriculture's drive towards higher value products, such as processed and animal-source foods that consume great amounts of energy, generate methane and other waste products, and are marketed and consumed heavily in unhealthy quantities.

For example, conceptualizing obesity as a global syndemic might have some utility. Obesity illustrates a pivotal syndemic problem that would appear to require international-level policy interventions to curb the power and influence of multinational corporations, representing Big Sugar and Big Food, which are seen as targeting low-income populations. Viewed within this particular context, advocating in favor of a global syndemic might serve as a constructive political tool to propel positive alliances to take action against multinational corporations. A related perspective is that tearing down silos in the academy and health policy; strengthening government action and community voices; dismantling corporate power to better designate who eats what and where; and promoting improved, more sustainable business models for a healthier future should be syndemic in nature.