TRENDS

Association of Schools Advancing Health Professions

FEBRUARY 2020

HIGHLIGHTS

Trends is the official newsletter of the Association of Schools Advancing Health Professions (122 C St. NW, Suite 200, Washington, D.C., 20001. Tel: 202-237-6481) Trends is published 10 times each year and is available on the Association's website at www.asahp.org. For more information, contact the editor, Thomas W. Elwood, Dr.PH.

GEOGRAPHIC INFLUENCE ON HEALTH DISPARITIES

Individuals possess distinguishing characteristics, such as age, education, level of income, extent of health insurance coverage, and degree of health literacy that contribute to the likelihood they will experience health disparities. Where they live and work also will play an important role due to a rural-urban divide that exists. For example, an article in the January 2020 issue of the *American Journal of Preventive Medicine* discusses how in the U.S., rural residents have poorer health than urban residents and this disadvantage is growing. Compared with metropolitan county residents, inhabitants of the most rural counties were seven percentage points more likely to have a usual source of care (81% vs 74%), but their providers were 13 percentage points less likely to be physicians (22% vs 35%). Despite having to travel longer to reach their usual source of care providers, residents of the most rural counties were 12 percentage points less likely than metropolitan residents to have usual source of care providers with office hours on nights and weekends (27% vs 39%).

Rural counties make up approximately 80% of the land area of this nation, but they contain less than 20% of the U.S. population. The relative sparseness of the population in rural areas is one of many factors that influence the health and well-being of the inhabitants of these places. An important difference pertaining to the health workforce is that some rural counties may lack the presence of a single member of a particular health profession, such as dentistry or psychiatry. Older patients with chronic ailments often require rehabilitation care, which typically requires a team consisting at a minimum of physicians, nurses, dietetians, occupational therapists, physical therapists, and speech therapists.

Hospitals often serve as the main type of venue where such teams are located, but as **Seema Verma**, Administrator of the Centers for Medicare & Medicaid Services, pointed out in a presentation she made on February 12, 2020 at the National Rural Health Association's policy institute, more than 120 rural hospitals have closed since 2010, which does not appear to be a step in the right direction of ensuring the presence of a sufficient network of health providers. Unlike students who live in big cities that have access to several academic institutions with health professions programs reachable by subway and bus, rural students lack this luxury and may live hundreds of miles from educational resources. Fortunately, telehealth services can benefit patients and online degree programs may be available to enable the pursuit of academic degrees necessary to become health professionals, but it is not the same as having face-to-face kinds of opportunities that exist in urban areas.

Health policy is in a state of flux. Some presidential candidates propose new approaches, such as *Medicare for All*, but it is not entirely clear what impacts possibly could materialize that affect the delivery of health care services. Changes in reimbursement patterns, for example, either could slow the pace of hospital closings in rural areas or accelerate their disappearance if financing levels prove to be less than what is necessary to enable these facilities to remain afloat financially.

PRESIDENT'S CORNER

By ASAHP President Phyllis King

A Blueprint for the Future (2020 – 2024) of the Association of Schools Advancing Health Professions

I am pleased to announce a new Strategic Plan is in place that articulates ASAHP's priorities and will focus our energy and resources to best serve the organization in accomplishing its mission of **advancing health through interprofessional collaboration.** This plan includes a shared vision of ASAHP being **THE source for interprofessional collaboration to improve health.**

Values driving our actions include quality education, interprofessional collaboration, connecting education and health, innovation, leadership and diversity. Five strategic areas of activity have been identified, each led by a board member with a committee structure, to achieve ASAHP's mission and vision:

- Communications, public relations and marketing – **Andrew Butler**
- Leadership development – **Deborah Larsen**
- Education – **Ces Thompson**
- Partnerships, alliances and advocacy – **Teresa Conner-Kerr**
- Research, member services and programs – **Brian Shulman**

Over the coming months you will receive more detailed information on the activities and metrics each committee is employing and how you can be involved. Member benefits of networking, professional development, research and development, the institutional profile survey, the leadership development program, representation on the Federal level and in other health organizations, and publications are retained with an eye toward adding even more value for members. Rest assured you have a dedicated leadership team excited to shape the future of ASAHP and adapt to ever changing environments with you.

TEAM ABOUT TO BREAK THE HUDDLE TO REVISE STRATEGIC PLAN

PULLING BACK THE CURTAIN

Two events that are prominent in the nation's annual political pageant enable voters to obtain a glimpse of the kinds of policies that may be concealed behind the curtain. One is the *President's State of the Union Address*, which makes it possible to boast of past achievements and describe in broad terms anticipated future legislative initiatives. While members of the President's party cheer vigorously at each utterance, Congressional members of the opposition party typically are more reticent. The second noteworthy event is the release by the Administration of its federal budget for the next fiscal year. Stock full of details on how money should be allocated, it's relatively easy to determine which budgetary elements are destined to undergo some exceptionally rough legislative sledding based on who cheered wildly at the State of the Union address and who remained silent.

Lobbyists and leaders of special interest groups pay close attention to the proposed federal budget. Each year, the plot lines in the drama are reasonably clear. Many liberals tend to fret that important discretionary social programs involving health care and education will be seriously underfunded, while proclaiming that some military programs are too bloated and either should be eliminated outright or undergo significant reductions in spending. Many conservatives view matters differently and it is rare for them to fail to acknowledge what they perceive as redundant and wasteful amounts of money allocated for ineffective social programs.

The budget sent to Congress on February 10, 2020 contained some of the following items:

- The administration proposes funding $38.7 billion for the National Institutes of Health (NIH) in FY 2021, which amounts to $3 billion less money or more than a 7% cut below the FY 2020 enacted program level.
- The Agency for Healthcare Research and Quality (AHRQ) would be funded as a new institute within the NIH in the amount of $257 million, representing an $82 million (24%) reduction below AHRQ's current funding level.
- On the plus side, the budget proposes a nearly $900 million increase in career and technical education funding.
- The Food and Drug Administration (FDA) would obtain a small budget increase in FY 2021 ($25 million, for a total of $3.29 billion).

Apart from legislation that involves spending, bipartisan cooperation has aided in producing efforts aimed at protecting patients from surprise medical billing. House Ways and Means Committee Chairman **Richard Neal (D-MA)** and Ranking Member **Kevin Brady (R-TX)** on February 7, 2020 announced the *Consumer Protections Against Surprise Medical Bills Act of 2020* while Education and Labor Committee Chairman **Robert "Bobby" Scott (D-VA)** and Ranking Member **Virginia Foxx (R-NC)** revealed their surprise billing legislation, the *Ban Surprise Billing Act*.

2020-2021 ASSOCIATION CALENDAR OF EVENTS

May 14-15, 2020—ASAHP Leadership Development Program Part I in Columbus, OH

October 26-27, 2020—ASAHP Leadership Development Program Part II in Long Beach, CA

October 28-30, 2020—ASAHP Annual Conference in Long Beach, CA

October 20-22, 2021—ASAHP Annual Conference in Long Beach, CA

HEALTH REFORM DEVELOPMENTS

Debates by candidates seeking to be the Democratic party's nominee to run against **President Donald Trump** in the upcoming election indicate that health care is a major policy issue that cries out for significant improvement. Proposals range from eliminating private forms of insurance coverage available through employers to protection offered solely by the federal government to a single-payer government operated program that also includes options for other forms of coverage. The latter choice recognizes that some beneficiaries may prefer having insurance provided by an employer rather than being compelled to participate in a governmental program.

Recent findings from the *National Health Interview Survey* help to highlight why some form of remediation is considered desirable. An estimated 14.2% of U.S. residents said they or a family member had problems paying medical bills in 2018, down from 19.7% in 2011, according to a report issued in February 2020 from the Centers for Disease Control and Prevention. The percentage of individuals in families having problems paying medical bills was higher among females (14.7%), children (16.2%), and non-Hispanic black persons (20.6%) compared with males, adults, and other racial and ethnic groups, respectively. Among persons under age 65, those who were uninsured were more likely than those with Medicaid or private coverage to have problems paying medical bills.

The Challenge Of Financing The Costs Of Health Care

National spending on healthcare is projected to grow 5.5% between 2018 and 2027, according to the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary's annual report that was issued in February last year. This growth would outpace average projected GDP growth by 0.8%. The forecast means the healthcare segment of the U.S. economy would climb to 19.4% by 2027, up from 17.9% in just two years. *Medicare for All* is one proposal being touted as a way of addressing the challenge of financing the cost of health care. Differences exist among advocates of this approach regarding whether it will be necessary to impose additional taxes. Individuals in favor of higher taxation believe that the amount beneficiaries must pay will be offset by eliminating other expenses associated with deductibles, co-payments and co-insurance.

A concern is that even if Medicare for All ever becomes the law of the land, there is no guarantee that it will be implemented and sustained as originally planned. The Affordable Care Act furnishes compelling evidence of the kinds of unintended alterations that can occur once a significantly large national endeavor leaves the launching pad. An original element of the ACA pertained to *Community Living Services and Supports (CLASS)* as a means of meeting the costs of long-term care. Seventeen months after the law was enacted, however, the HHS Secretary announced that CLASS would be abandoned because it was unsound financially. Reforming the federal tax code in 2017 resulted in repeal of the individual mandate to purchase health insurance or pay a penalty for failing to do so. In December 2019, legislation was enacted to eliminate three mechanisms designed to pay for the ACA: the so-called "Cadillac Tax", the "Health Insurer Tax", and the "Medical Device Tax."

Curbing Waste In The Provision Of Health Care Services

A review of 54 unique peer-reviewed publications, government-based reports, and reports from the gray literature described in the October 15, 2019 issue of the *Journal of the American Medical Association* yielded the following estimated ranges of total annual cost of waste: (1) failure of care delivery, $102.4 billion to $165.7 billion, (2) pricing failure, $230.7 billion to $240.5 billion, (3) fraud and abuse, $58.5 billion to $83.9 billion, and (4) administrative complexity, $265.6 billion. The estimated annual savings from measures to eliminate waste were as follows: (1) failure of care delivery, $44.4 billion to $97.3 billion, (2) pricing failure, $81.4 billion to $91.2 billion, and (3) fraud and abuse, $22.8 billion to $30.8 billion. No studies were identified that focused on interventions targeting administrative complexity. The estimated total annual costs of waste, including items not listed here, were $760 billion to $935 billion and savings from interventions that address waste were $191 billion to $286 billion.

DEVELOPMENTS IN HIGHER EDUCATION

It is a tossup on any given day in the nation's capital whether health care or education can result in the most congressional perturbations. Education definitely can holds its own when it comes to demonstrating a proclivity for generating partisan-oriented activity. February 2020 was marked by groups representing the nation's colleges and universities in the act of rebuking a Trump administration proposal aimed at punishing institutions for violating students' free speech rights. Proposed regulations would allow the U.S. Department of Education to cut off some federal grants to public colleges that don't comply with the First Amendment or private universities that don't follow their own campus speech policies. Under the proposal, department officials would rely on the "final judgement" of a court in determining whether a school violated the First Amendment and should lose access to funding.

The American Council on Education (ACE), along with several other national education organizations, responded by indicating that the proposed rule would encourage excessive and frivolous litigation in ways that undermine the Department's and academia's shared goal to maintain broad protections for campus speech. Another concern is that courts will reach different conclusions as to whether an institution violated the First Amendment or its stated policies, even when looking at the same or similar set of facts. Also, unique considerations in the freedom of speech context call for greater clarity in defining when the Department may terminate federal grant funding.

If the Department proceeds with its proposed rule, the education groups offer the following recommendations to minimize some of the more problematic aspects: (1) Modify the trigger for when an institution is deemed to be out of compliance with the First Amendment or its stated policies, (2) Provide clearer criteria under which the Department will attempt to terminate or suspend a federal grant, (3) Strike from the text of the regulation references to "academic freedom" as well as the clause that attempts to enumerate specific rights under the First Amendment, (4) Extend the window for submitting notice of a final judgment to the Department, and (5) Remove language from the preamble that would require private institutions to certify to the Secretary compliance with institutional policies on free inquiry as a material condition of an award.

A Bipartisan Proposal For Reauthorization Of The Higher Education Act (HEA)

A task force convened by the Bipartisan Policy Center over an 18-month period examined a variety of issues and conducted modeling, where relevant data were available, to inform decision-making. Recommendations in a report issued in January 2020 are aimed at advancing multiple objectives: promoting college affordability and reducing equity gaps; strengthening institutional accountability while also ensuring that low-capacity institutions have the resources needed to succeed; simplifying the federal student loan program and reducing unsustainable borrowing; and providing better information and data to policymakers, researchers, and, most importantly, students and families. Specific challenges that must be addressed to ensure the U.S. higher education system meets the needs of students and the economy are: Access and Affordability; Outcomes and Accountability; and Data and Information.

Access and Affordability: Twenty-three recommendations were identified to address the need for improvement and reform in areas, such as (1) Renewing the federal-state partnership in higher education, (2) Strengthening the federal Pell Grant program, and (3) Reforming the federal student loan program.

Outcomes and Accountability: Ten recommendations were identified to promote quality assurance, increase schools' capacity to support students and deliver better student outcomes, and give postsecondary institutions stronger incentives for improvement.

Data and Information: Twelve recommendations were identified to address a lack of high-quality data on student outcomes and institutional behavior; prepare students to understand and make informed decisions regarding federal financial aid; and aid in comparing financial implications of one institution over another.

QUICK STAT (SHORT, TIMELY, AND TOPICAL)

2020 Patient Data Breach Barometer

In 2019, the healthcare industry continued to be plagued by data breaches involving sensitive patient information, with public reports of hacking jumping a staggering 48.6% from 2018. This number of reported hacking incidents is a reminder of how vulnerable patient data remain. An analysis by *Protenus* is based on 572 health data breaches reported to the U.S. Department of Health and Human Services (HHS), the media, or some other source during 2019. For the 481 incidents where data exist, breaches had an impact on 41,404,022 patients, which is likely to be a huge underestimate. Two incidents for which there were no data affected 500 dental practices and clinics and could affect significant volumes of patient records. The number of breaches went from 503 in 2018 to 572 in 2019, along with a substantial increase in the number of affected records. In 2019, the total number of affected records almost tripled when compared to 2018 data (i.e., 15,085,302 affected records).

Self-reported Marijuana Use In Electronic Cigarettes Among U.S. Youth

The National Youth Tobacco Survey (NYTS) is a cross-sectional, school-based study conducted annually using a stratified, three-stage cluster sampling design to produce a nationally representative sample of middle school (grades 6-8) and high school (grades 9-12) students in the U.S. They were asked about whether they ever have used marijuana in an e-cigarette. As reported in the February 4, 2020 issue of the *Journal of the American Medical Association*, the study identified a significant increase in self-reported ever marijuana use in e-cigarettes from 2017 to 2018 among U.S. students. Prevalence estimates reported for all students (14.7%) and current e-cigarette users (53.5%) in 2018 also were much higher than those reported in 2016 (8.9% and 39.5%, respectively). The increase in marijuana use in e-cigarettes could be attributable to the increase of sales of pod-mod–style e-cigarette products, access to marijuana through informal sources (e.g., friends, family members, illicit dealers), and reduced perception among adolescents of the harms of marijuana use.

HEALTH TECHNOLOGY CORNER

Light-Adapted Electroretinogram Differences In Autism Spectrum Disorder

A new eye scan could help identify autism in children years earlier than currently possible. This non-invasive device uses a hand-held instrument to locate a pattern of subtle electrical signals in the retina that are different in children on the autism spectrum. According to a manuscript published on February 7, 2020 in the *Journal of Autism and Developmental Disorders*, the retina is an accessible model of neural connectivity in the brain where specific retinal signaling pathways can be probed and measured with an electroretinogram (ERG). Light-adapted (LA) electroretinograms (ERGs) of individuals with autism spectrum disorder (ASD) were compared to control subjects in a multicenter study of children. The results show that the LA-ERG is a potential marker for neurodevelopmental conditions, such as ASD in children. These potential biomarkers for ASD also could allow for early detection of other disorders, such as attention deficit hyperactivity disorder (ADHD).

Evolving Magnetically Levitated Plasma Proteins Detect Opioid Use Disorder As A Model Disease

As reported on January 29, 2020 in the journal *Advanced Healthcare Materials*, new research from the University of British Columbia, Harvard Medical School, and Michigan State University suggests that levitating human plasma may lead to faster, more reliable, portable, and simpler disease detection. The researchers used a stream of electricity that acted like a magnet and separated protein from blood plasma, which is the clear, liquid portion that remains after red blood cells, white blood cells, platelets, and other cellular components are removed. The basic notion is that as plasma proteins are different densities, when separated the proteins levitate at different heights, and therefore become identifiable. An evaluation of these types of proteins and how they group together can produce a picture that identifies whether a patient has the possibility of contracting a disease or becoming addicted to drugs, such as opioids.

AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Clinical Prevention and Population Health Curriculum Framework

The Association for Prevention Teaching and Research (APTR) announced the release of the newly revised *Clinical Prevention and Population Health Curriculum Framework*, which undergoes revision and public comment every five years, and is the result of almost two years of review and deliberation by the Healthy People Curriculum Task Force (HPCTF). This group's mission is to achieve Healthy People objectives of increasing health promotion, disease prevention, population health, and interprofessional learning experiences for students in health professions education programs. Kenneth Johnson, Associate Dean of the Dumke College of Health Professions at Weber State University, represented the Association of Schools Advancing Health Professions (ASAHP) in this important endeavor. The Clinical Prevention and Population Health Curriculum Framework provides a common core of knowledge for clinical health professions about individual and population-oriented prevention and health promotion efforts. The Framework can support interprofessional prevention education and practice. The 4th revision of the Framework features: a new domain addressing mental and behavioral health; greater emphasis on Social Determinants of Health (SDOH) and health equity; improved, updated illustrative examples; and 14 new or revised topic areas. The Framework can be obtained at https://www.teachpopulationhealth.org/uploads/2/1/9/6/21964692/cpph_framework_feb2020.pdf.

Precarious Work Schedules And Population Health

According to a new brief from the journal *Health* Affairs, work has become more precarious in America over the past half century as employers have transferred more of the risks and uncertainties of doing business onto workers and households. As part of this shift, many workers have experienced an erosion of job quality—reductions in the real value of their wages; a loss or cutback of fringe benefits such as retirement plans and health insurance; and an increase in job insecurity. Policymaking responses to the rise in precarious employment have commonly focused on the economic dimensions, exemplified by appeals for a living wage. Yet, alongside changes in the economic dimension, the temporal dimension of work also has undergone seismic shifts. Unstable and unpredictable work schedules have become the new normal for many workers as the U.S. economy has shifted from manufacturing to service-sector jobs—and from steady Monday through Friday, 9–5 work hours—to a 24/7 economy. The brief synthesizes research findings that allow dots to be connected between precarious work schedules and health, and gaps are identified that remain to be filled. The brief can be obtained at https://www-healthaffairs-org.proxy.libraries.rutgers.edu/do/10.1377/hpb20200206.806111/full/brief_workforce_health_Harknett.pdf.

Quantification Of U.S. Neighborhood-Level Social Determinants Of Health

The consequences of social determinants of health (SDOH) increasingly dominate public health discussions in the U.S. as population health outcomes have not kept pace with those of other developed nations despite higher per-person spending for medical services. A report in the journal *JAMA Network Open* on January 29, 2019 looks at geographic variation in social determinants of health in the continental U.S. Fifteen variables, measured as a five-year mean, were selected to characterize SDOH as small-area variations for demographic characteristics of vulnerable groups, economic status, social and neighborhood characteristics, and housing and transportation availability at the census-tract level. This data matrix was reduced to four indices reflecting advantage, isolation, opportunity, and mixed immigrant cohesion and accessibility, which then were clustered into seven distinct multidimensional neighborhood typologies. The report can be obtained at https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759757.

THE ROAD TO IMMORTALITY IS PAVED WITH EPONYMS

The health sphere represents fertile ground for the production of eponyms. Prominent examples are Salk vaccine, Alzheimer's disease, Parkinson's disease, and Obamacare. Perpetual glory appears to be associated with having one's name used in such ways and the website *Whonamedit.com* provides thousands of examples of medical eponyms. Is the practice of employing them a constructive use of nomenclature or has it become more timeworn than beneficial? This kind of question is addressed in a manuscript that appeared in the February 11, 2020 issue of the journal *Neurology* in which a study is described that assesses historical trends of medical eponym use in neurology literature, and knowledge and attitudes among current trainees related to eponyms. The yearly prevalence of eponyms among neurologist-authored publications ranged from 15% and 25%, with a mean of 21%. The total number of unique eponyms appearing in titles and abstracts increased from 693 in 1988 to 1,076 in 2013, representing 1.8% average annual growth.

Worth noting is that medical eponyms represent a polarizing issue among clinicians, including neurologists. Impassioned calls for the abandonment of eponyms in the published literature and in clinical use have appeared regularly in the literature for decades. Supporters explain that eponyms are concise and memorable, providing an effective shorthand to communicate precisely in clinical settings. Eponyms also may represent an essential thread of medical history, an oral tradition transmitted to successive generations of students through teaching rounds. An opposing perspective is that eponyms can be viewed as lacking accuracy and being characterized by inconsistent usage, frequent misattribution of credit, and occasional recognition of individuals with unethical research practices, such as Nazi-affiliated physicians. Study findings indicate that residents with at least one year of neurology training reported familiarity with significantly more eponyms than those before neurology training ($p < 0.001$). For familiar eponyms, most residents either were unaware of an alternative descriptor or preferred using the eponym. Despite recognizing both the benefits and drawbacks of eponyms, the vast majority of trainees stated that historical precedent, pervasiveness, and ease of use would drive the continued use of eponyms in neurology. For the nonce, it seems reasonable to predict that this path to immortality will remain open.

QUANTIFYING HEALTH SYSTEMS' INVESTMENTS IN SOCIAL DETERMINANTS OF HEALTH

Social determinants (e.g., conditions in which individuals are born, grow, work, live, and age) are seen as accounting for substantially more of the variation in health outcomes than medical care does while interest in addressing these determinants has increased markedly in recent years. According to a study reported in the February 2020 issue of the journal *Health Affairs*, the past decade has involved a growing recognition of the importance of social determinants of health for health outcomes. Meanwhile, the degree to which health systems in the U.S. are investing directly in community programs to address social determinants of health as opposed to screening and referral is uncertain.

Researchers conducting this investigation searched for all public announcements of new programs involving direct financial investments in social determinants of health by U.S. health systems from January 1, 2017, to November 30, 2019. They identified 78 unique programs involving 57 health systems that collectively included 917 hospitals. The programs involved at least $2.5 billion of health system funds, of which $1.6 billion in 52 programs was committed specifically to housing-focused interventions. Additional focus areas were employment (28 programs, $1.1 billion), education (14 programs, $476.4 million), food security (25 programs, $294.2 million), social and community context (13 programs, $253.1 million), and transportation (six programs, $32 million). These figures demonstrate that health systems are making sizable investments in social determinants of health. To cite one example, housing-related programs included strategies, such as direct building of affordable housing, often with a fraction set aside for homeless patients or those with high use of health care; funding for health system employees to purchase local homes to revitalize neighborhoods; and eviction prevention and housing stabilization programs.