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ASSOCIATION OF SCHOOLS OF  
ALLIED HEALTH PROFESSIONS

*Vanguard of  
Allied Health Education*

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## HEALTH REFORM AND NOSOLOGY

Once again, Congress is embroiled in controversy over health reform. This time around, the battle is how to dismantle and replace the Affordable Care Act that became law in 2010. A major aim in both cases entails the provision of quality, affordable insurance coverage. Assuming that such protection ever becomes available for all inhabitants of the U.S., what is likely to transpire?

Bearing insurance cards, beneficiaries will be able to enter the health care domain in large numbers seeking to prevent disease or obtain treatment for their maladies. The June 2017 issue of the journal *Molecular Psychiatry* furnishes some interesting thoughts along such lines. One article discusses how in the field of psychiatry, the relative virtues of a syndromal versus etiologic nosology have been debated since the 1800s. Not only do individual risk factors contribute to several different disorders, but many disorders can be influenced by several etiologic factors. A problem is that causes and effects can prove to be troublesome to differentiate.

The aged segment of the U.S. population is growing rapidly. So-called baby boomers started to become eligible for Medicare at a rate of 10,000 per day over a 19-year period that began on January 1, 2011. Nearly 40% of individuals age 65 and older had at least one disability, according to a December 2014 U.S. Census Bureau report. Among this age group, many of their diseases come under the rubric of rheumatology where it can be highly challenging to discern whether syndromal or etiologic factors are more significant in arriving at correct differential diagnoses.

Diagnosis of several rheumatic diseases is difficult because clinical manifestations may be the same as what occurs in other diseases. Attacks and remissions may happen and during attacks, the symptoms may not be identical for the same disease. For example, females tend to be more likely to experience Fibromyalgia syndrome (FMS), which is defined by the presence of generalized pain, fatigue, sleep disorders, multiple somatic symptoms, and cognitive problems. Pain and inflammation in patients with inflammatory arthritis play a role in the development and course of FMS. Compounding matters further, the presence of systemic lupus erythematosus adds to the diagnostic challenge since both diseases share common symptomology. To cite another example, patients with psoriatic arthritis might either be misdiagnosed or go undiagnosed while showing symptoms of psoriasis.

Aside from the absence of suitable diagnostic biomarkers and debates over whether a rheumatic disease should be classified as either an autoimmune disease, an auto inflammatory disease, or a vascular disease, patient attributes such as treatment adherence and health literacy will influence outcomes. The health workforce represents one more set of highly critical factors that also must be addressed. A certain portion of it must possess the necessary skills to conduct research. A corollary is the necessity of having sufficient resources to finance investigations. Achieving optimal interprofessional cooperation is one more critical element that will have an impact on efforts to treat patients effectively.

## PERSPECTIVE FROM THE PRESIDENT'S CORNER

By Linda Petrosino, ASAHP President



Already at the end of June heading into July, and while for many the summer means a slower pace, I assure you that our members and the ASAHP Board continue to be active. It is a pleasure to provide a brief glimpse of some of the activities consistent with moving ASAHP strategic priorities forward. For example, Dean **Stacy Gropack** from Long Island University —C.W. Post Campus and Association Executive Director **John Colbert** attended the summer Interprofessional Education Collaborative (IPEC) where the topic of discussion was on mental health issues for both practitioners and students.

A recent article in *USA Today College* featured headlines stating: “More and more students need mental health services, but colleges struggle to keep up.” Having talked to colleagues across the country I know that we are struggling with how to best support our students and it is therefore important to have ASAHP at the table as issues like this and many others continuing to influence interprofessional education and practice are discussed.

The International Task Force met at the Kessler Institute June 15 & 16 to continue to collaborate around addressing the challenges surrounding staffing needs that exist for global health care. The newly created *ASAHP Student Assembly* has developed By-Laws for review by the Board of Directors and they have created their first newsletter printed Summer 2017. Both the International Task Force and the Student Assembly have been facilitated by Past President **Rich Oliver** as he continues his tremendous service to ASAHP.

The ASAHP Board will convene on July 10 & 11 to continue its work on behalf of member institutions and collaborative partners. During this meeting the Board will discuss the work of the International Task Force to determine future direction and will review the Student Assembly By-Laws for endorsement. The Board will also use this opportunity to continue to discuss the recruitment of member institutions that have not yet found ASAHP. The Board will hear the progress of all of the strategic priority committees and their work and will help fine tune direction.

Our meeting would not be complete without hearing the most up to date Washington occurrences as it relates to those issues of importance to our members. The summer work of the Board and various committees will continue including the work of the Annual Conference planning committee that is securing speakers and organizing the program for the Annual Conference. Details of the conference will be coming soon so stay tuned for information about speakers and registration (<http://www.asahp.org/conferences>).

So, while we enjoy the more relaxing pace of summer, we continue the work that is important for all of our members and those whom we serve.

On behalf of the ASAHP Board, I wish you a relaxing and joyful summer.

Linda



## SENATE HEALTH REFORM EFFORTS

Republicans have insisted over the past three election cycles that if they were able to take over control of the White House and both Congressional chambers, they would repeal and replace the Affordable Care Act. Now that they are the dominant power in the nation's capital, they are discovering that carrying out their intentions is not going to be easy. In March of this year, House Republican leaders had to withdraw the American Health Care Act because it did not have enough votes to achieve passage. A reworked version barely passed by only four votes when it was reintroduced in early May. Notably, the initiative did not attract a single vote by Democrats.

Members of the Senate reacted to the House bill by indicating that their enthusiasm for it was somewhat less than total. Vows were made to produce a version of their own that would contain significant differences. On June 22 of this year, their version of the legislation—the Senate Better Care Reconciliation Act—was introduced, but underwent its own revision only four days later when changes were made involving some provisions in the stability and innovation funds section to allow both short and long-term funds to be used to purchase health insurance benefits and make a significant change regarding individual market requirements.

According to an analysis from the Congressional Budget Office that was released on June 26, this proposed legislation to overhaul the Affordable Care Act would leave an additional 22 million individuals without health care coverage over the next decade. News of that sort is not destined to generate overwhelming support and the results have been predictable. Not only Democrats have expressed displeasure with the bill, complaints have been issued by major health care providers in the hospital sector, to cite just one example.

Apart from health reform, Congress must focus on other business pertaining to health. NIH Director **Francis Collins** appeared at a Senate Labor-HHS-Education Appropriations Subcommittee hearing on June 22, 2017. An area of concern for both Subcommittee Republicans and Democrats is the Administration's proposal to limit support for indirect costs when awarding grants. A reduction in NIH facilities and administrative (F&A) support to 10% of extramural research funding is being looked upon as jeopardizing the viability of existing research programs. F&A currently averages around 28%.

Another concern is a proposal to eliminate the NIH's Fogarty International Center. **Anthony Fauci**, Director of the NIH's National Institute of Allergy and Infectious Disease (NIAID), has described the center as central to recent efforts to combat Ebola and Zika by training scientists abroad because infectious diseases have a long history of ignoring borders.

### 2017-2018 ASSOCIATION CALENDAR OF EVENTS

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

**September 2017**—ASAHP Election Results Announced

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

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

## AFFORDABLE CARE ACT DEVELOPMENTS

As described on the previous page of this newsletter, Congressional Republicans actively continue their aim to repeal and replace the Affordable Care Act (ACA). A bill called the America Health Care Act (AHCA) was introduced in the House of Representatives in March 2017, but later withdrawn when it became evident that there would not be enough votes to pass it. Not only did some conservative Republicans oppose it, there was no indication that any Democrats would vote affirmatively. Modifications subsequently were made. It then was reintroduced and passed by only a four-vote margin. No Democrats voted in support.

Some Republicans in the Senate then reacted negatively and indicated that they would produce their own version with major differences. Their bill was introduced on June 22 and then an amended bill was released shortly thereafter. Various health care provider organizations and Democrats criticized that product, indicating that the proposed legislation would increase the number of Americans who will lack health insurance. As many as five Republicans claimed that they may not vote to pass it. If that outcome were to occur, since there are only 52 Republicans in the Senate, passage of the AHCA will not be achieved. Thus, as of the end of June 2017, it remains unclear if and when any changes in the ACA will take place.

### **ACA Impact On Coverage And Access For Patients With Pre-Existing Conditions**

A Commonwealth Fund study released in June 2017 revealed that between 2013 and 2015, 16.5 million non-elderly adults gained coverage following full ACA implementation. Of those individuals, 2.6 million had pre-existing conditions that otherwise could have precluded them from coverage because of discriminatory denials and pricing. Another 9.4 million had conditions that otherwise could have affected insurance cost. Researchers found strong correlations between these coverage gains and access to care. Coverage and access gains for patients with pre-existing conditions were unrelated to the size or existence of the state high-risk pools that 35 states funded for such individuals pre-ACA. The findings suggest that proposals to replace current protections for individuals with pre-existing conditions with high-risk pools are unlikely to be sufficient to maintain the ACA's gains.

### **Insurance Coverage And Premium Costs In Public Exchanges**

Insurance firms around the nation continue to indicate that they are withdrawing from providing coverage in the ACA's public exchanges. Washington state has no insurer willing to offer Affordable Care Act plans in 2018 in two of its 39 counties, opening up a third U.S. region that is poised to be without coverage through the health law's marketplaces. The announcement from that state insurance regulator may add to political pressure over the status of these marketplaces to provide coverage, which are showing signs of strain in the nation. Premera Blue Cross indicated that it will pull out of a total of four of the 27 Washington counties where it currently sells ACA exchange plans. In related actions, 18 counties in Ohio have no exchange insurer signed up for next year in the wake of Anthem Inc.'s decision to pull out of that state's marketplace. Blue Cross and Blue Shield of Kansas City's planned exit from the ACA exchanges means that 25 counties in western Missouri will be affected similarly in 2018 unless other companies fill the void. The departure of these companies has a negative impact on the Affordable Care Act. The law was designed to function in a way that mandates coverage through the exchanges, which then makes it possible for purchasers to obtain government subsidies to offset costs by obtaining coverage in this manner.

Monthly premiums in public exchanges run by the federal government have doubled since 2013, according to the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE). ASPE analyzed premium increases since the Affordable Care Act (ACA) went into effect, comparing 2013 and 2017 premiums. For the 39 states that use HealthCare.gov, the average monthly premium increased from \$232 in 2013 to \$476 in 2017. New Jersey's average monthly premium increase was the lowest (12%), and Alabama's, which was the highest, more than doubled. Overall, three states had an average monthly premium increase that also more than doubled.

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## DEVELOPMENTS IN HIGHER EDUCATION

The development of federal policy is manifested in two interconnected ways. First, depending on the willingness of a President to sign Congressional legislation into law, a finished bill expresses in broad terms what lawmakers want to have accomplished. Second, once the legislation is enacted, whatever agencies are involved then begin to produce regulations and memoranda of understanding to translate the broad strokes into specific actions to be implemented.

Congress often develops new laws, while also having responsibility for reauthorizing existing laws that have expired. The original Higher Education Act (HEA) is a highly important law created in 1965. A sweeping effort that governs federal higher education programs, it has been rewritten eight separate times. The current HEA was set to expire at the end of 2013 but was extended through 2016 while Congress works on the next reauthorization.

### The Future Of Specialized And Professional Accreditation

The Council for Higher Education Accreditation (CHEA) has commissioned a series of op-ed commentaries on issues related to accreditation and quality assurance. **Joseph Vibert**, Executive Director of the Association of Specialized and Professional Accreditors offered his thoughts about these issues in June 2017. He stated that professional accreditation has a proud history of sustaining good accreditation practice and enforcing standards so that academic programs produce effective and safe practitioners who serve the public good. Recently publicized misperceptions that demonize peer review and limit the definition of good outcomes to graduation and retention rates; debt; repayment and default rates; and earnings and job placement rates are woefully short-sighted. Determination of whether graduates of professional programs are competent to practice is the focus of specialized and professional accreditors – and the future of accreditation depends on this concept.

The foundation of professional and specialized accreditation (also called programmatic accreditation) is the inclusive process wherein subject matter experts set national accreditation standards and determine competencies. For any given profession, these content experts (peers) include practitioners, employers and industry, educators, professional associations, and other communities of interest. Competencies are the knowledge, skills, and abilities necessary for safe and effective practice in a profession. Competencies encompass critical thinking and the ability to adapt and to create knowledge that is essential for the evolution of professional practice in response to a changing environment.

### Rulemaking Committees To Review Obama Administration's Regulations

On June 14, 2017, U.S. Secretary of Education **Betsy DeVos** announced the Department's intention to establish rulemaking committees on *Borrower Defense to Repayment (BDR)* and *Gainful Employment (GE)* regulations. She stated, "My first priority is to protect students. Fraud, especially fraud committed by a school, is simply unacceptable. Unfortunately, last year's rulemaking effort missed an opportunity to get it right. The result is a muddled process that's unfair to students and schools, and puts taxpayers on the hook for significant costs. It's time to take a step back and make sure these rules achieve their purpose: helping harmed students. It's time for a regulatory reset. It is the Department's aim, and this Administration's commitment, to protect students from predatory practices while also providing clear, fair and balanced rules for colleges and universities to follow." Due to pending litigation challenging the BDR regulations, the Department is postponing the effective date pursuant to section 705 of the Administration Procedures Act. While negotiated rulemaking occurs, the Department will continue to process applications under the current borrower defense rules. A Notice of Intent to Conduct Negotiated Rulemaking on BDR and GE appeared in the *Federal Register* on June 16, 2017. Public hearings on BDR and GE are scheduled for July 10, 2017, in Washington, D.C. and July 12, 2017, in Dallas, Texas.

## QUICK STAT (SHORT, TIMELY, AND TOPICAL)

### **Women And Doctorates In Science, Technology, Engineering, And Mathematics (STEM)**

The proportion of women obtaining PhDs in science, technology, engineering and mathematics (STEM) in the United States has remained stagnant in the past decade, despite a 50% increase in the number of STEM doctorates awarded in the same period. The figures, released by the National Student Clearinghouse Research Center in Herndon, Virginia in its report *Snapshot 27: Science and Engineering Degree Completion by Gender*, showed that although the number of STEM PhDs rose from about 18,000 in 2006 to more than 27,000 in 2016, the proportion of doctorates awarded to women remained at around 40%. The report offers the first national-level snapshot of science and engineering degrees awarded in 2015–16, which the center compared with those earned in 2006. The proportion of PhD degrees earned by women fell slightly from 29.2% to 28.4% in mathematics. They earned 51.8% of PhDs in biological and agricultural sciences in 2016.

### **Misuse Of Prescription Pain Relievers**

About 12.5 million U.S. residents reported misusing prescription pain relievers in 2015, according to a release on June 12, 2017 by the Substance Abuse and Mental Health Services Administration. More than half of them obtained their most recently misused pain reliever from a friend or relative, notes the report, which summarizes data on substance use, depression, serious mental illness, and related treatment from the 2015 National Survey on Drug Use and Health and National Survey of Substance Abuse Treatment Services. The number of individuals receiving buprenorphine to treat opioid use more than doubled between 2013 and 2015 to nearly 76,000. Among other findings, an estimated 13% of youth aged 12-17 experienced a major depressive episode in 2015, including one in five girls. This analysis is being viewed by government officials as helping public health authorities and others determine the best ways of meeting behavioral health care needs and disparities among various communities.

## HEALTH TECHNOLOGY CORNER

### **Passive Elastography: A Shear Wave Tomography Of The Human Body**

Elastography, sometimes referred to as seismology of the human body, is an emerging technology used to enhance medical ultrasound imaging. It does so by measuring the elasticity of biological tissue to diagnose cancer or liver and thyroid disease more accurately and at the earliest stages. In passive elastography, the elasticity of tissue is measured using the body's own propagation of shear waves, which enables more effective imaging deeper inside the body in an even more non-invasive way than traditional elastography. As discussed at the joint meeting of the Acoustical Society of America and the European Acoustics Association held in June in Boston, passive elastography is foreseen as a viable technique for cancer detection in organs deep in the body, such as the liver, and for well-protected organs such as the brain.

### **Developing Snapshots Of Neural Activity**

As reported in the June issue of *Nature Biotechnology*, a team of MIT and Stanford University researchers has developed a way to label neurons when they become active, essentially providing a snapshot of their activity at a given moment. The approach could offer significant new insights into neuron function by offering greater temporal precision than current cell-labeling techniques, which capture activity across time windows of hours or days. This tool has potential for helping to decipher neural circuits involved in learning and memory. It was designed to respond to calcium, because neurons experience a flux of calcium ions every time they fire an electrical impulse. A combination of light exposure and calcium activity triggers the activation of a transcription factor that turns on a target gene that the researchers have engineered into the cells' genome. This gene could encode a fluorescent protein or anything else that could be used to label or manipulate neurons. The technique in this study labeled FLARE acts by turning on a red fluorescent protein called mCherry in the motor cortex neurons of mice.

## **AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY**

### **Protecting The Health And Well-Being Of Communities In A Changing Climate**

A March 13, 2017 workshop explored the implications of climate change for population health and the potential mitigation and adaptation strategies for public health, environmental health, and health care. The workshop also explored a range of perspectives from local government, civil society organizations, and health care organizations, and showcased practical examples of strategies to address climate effects on population health. A brief proceedings of the workshop was prepared by designated rapporteurs in accordance with institutional guidelines as a factual summation of the sessions discussed. The one-day public event was co-hosted by the Roundtable on Environmental Health Sciences, Research, and Medicine and the Roundtable on Population Health Improvement, two convening activities of the National Academies of Sciences, Engineering and Medicine. The workshop report can be obtained at <https://www.nap.edu/read/24797/chapter/1>.

### **Projected Health Insurance Exchanges Participation**

The Centers for Medicare & Medicaid Services (CMS) released a county-level map of 2018 projected Health Insurance Exchanges participation based on the known issuer participation public announcements through June 9, 2017. The map shows that insurance options on the Exchanges continue to disappear. In some areas, Americans will have no coverage options on the Exchanges, based on the current data. The CMS map displays point in time data and is expected to fluctuate as issuers continue to make announcements on exiting or entering specific states and counties. It currently shows that nationwide 47 counties are projected to have no insurers, meaning that Americans in these counties could be without coverage on the Exchanges for 2018. It's also projected that as many as 1,200 counties - nearly 40% of counties nationwide - could have only one issuer in 2018. It is expected that the number of consumers with no coverage choices will rise. The map can be obtained at <https://downloads.cms.gov/files/ccioo-exchange-carriers-by-county.pdf>.

### **Health Communication With Immigrant, Refugee, And Migrant Worker Populations**

In March 2017, the Roundtable on Health Literacy of the National Academies of Sciences, Engineering, and Medicine convened a workshop focused on health communication with persons from immigrant, refugee, and migrant worker populations. The workshop was organized to explore the application of health literacy insights to the issues and challenges associated with addressing the health of immigrants, refugees, and migrant workers. Participants explored issues of access and services for members of these populations as well as outreach and action. A report summarizes the presentations and discussions from the workshop. The report can be obtained at <https://www.nap.edu/catalog/24796/health-communication-with-immigrants-refugees-and-migrant-workers-proceedings-of>.

### **Congressional Budget Score Of The Senate Health Reform Bill**

The Congressional Budget Office (CBO) and the staff of the Joint Committee on Taxation (JCT) completed an estimate of the direct spending and revenue effects of the Better Care Reconciliation Act of 2017, a Senate amendment in the nature of a substitute to the American Health Care Act. The Senate bill would increase the number of individuals who are uninsured by 22 million in 2026 relative to the number under current law, slightly fewer than the increase in the number of uninsured estimated for the House-passed legislation. The analysis can be obtained at <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf>.

## WHAT IS HEALTH EQUITY?

A report from the Robert Wood Johnson Foundation that was released in May 2017 is entitled, *What Is Health Equity? And What Difference Does a Definition Make?* It defines health equity and identifies crucial elements to guide effective action to reduce disparities in health status. Also included in the report are alternative definitions of health equity for different audiences that may have varying backgrounds and perspectives, and examples of specific terms that often arise in discussions around the concept.

Four key steps to achieve health equity are:

- **Identify important health disparities.** Many disparities in health are rooted in inequities in the opportunities and resources needed to be healthier. The determinants of health include living and working conditions, education, income, neighborhood characteristic, social inclusion, and medical care. An increase in opportunities to be healthier will benefit everyone, but more focus should be placed on groups that have been excluded or marginalized in the past.
- **Change and implement policies, laws, systems, environments, and practices to reduce inequities in the opportunities and resources needed to be healthier.** Eliminate the unfair individual and institutional social conditions that give rise to the inequities.
- **Evaluate and monitor efforts using short- and long-term measures** as it may take decades or generations to reduce some health disparities. In order not to underestimate the size of the gap between advantaged and disadvantaged, the latter groups should not be compared to the general population, but to advantaged groups.
- **Reassess strategies in light of process and outcomes and plan next steps.** Actively engage those most affected by disparities in the identification, design, implementation, and evaluation of promising solutions.

## HEALTH DISPARITIES AND TRANSPLANT ALLOCATIONS

According to an article that appeared in the June 2017 issue of the journal *Health Affairs*, as of the end of 2014, nearly 700,000 patients had end-stage renal disease. Once diagnosed, these individuals qualify for Medicare coverage. Their care cost Medicare \$32.8 billion in 2014. Kidney transplantation is the preferred treatment for most patients with this disease because it offers longer survival, better quality of life, and fewer hospitalizations, compared to dialysis. Before the 2014 implementation of a new kidney allocation system by the United Network for Organ Sharing, white patients were more likely than black or Hispanic patients to receive a kidney transplant. To determine the effect of the new allocation system on these disparities, researchers examined data for 179,071 transplant waiting list events in the period June 2013–September 2016 and calculated monthly transplantation rates (34,133 patients actually received transplants). Implementation of the new system was associated with a narrowing of the disparities in the average monthly transplantation rates by 0.29% for blacks compared to whites and by 0.24% for Hispanics compared to whites, which resulted in both disparities becoming non-significant after implementation of the new system.

Racial/ethnic disparities affecting blacks and Hispanics exist at each step of the kidney transplant process, with members of minority groups on average being less likely to complete the necessary medical evaluation, be placed on the national waiting list, and receive a transplant. A number of characteristics of health care systems, patients, and providers are correlated to these disparities, including poverty, limited numbers of dialysis facility staff members to educate patients about transplantation, physician bias, and inequitable federal policies that guide US organ allocation.