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Trends

Association of Schools of Allied Health Professions

HIGHLIGHTS

MARCH 2015

ASAHP

ASSOCIATION OF SCHOOLS OF ALLIED HEALTH PROFESSIONS

Vanguard of Allied Health Education

Trends is the official newsletter of the Association of Schools of Allied Health Professions (122 C St. NW, Suite 650, Washington, D.C., 20001. Tel: 202-237-6481) Trends is published monthly and available on the Association's website at www.asahp.org. For more information, contact the editor, Thomas W. Elwood, Dr.PH.

PATIENTS AND THEIR CAREGIVERS: CONVERGENCE OR COLLISION?

Developments in health care continue to occur at a steady pace in the U.S. Earlier this month, the Department of Health & Human Services (HHS) announced that 11.7 million Americans enrolled in coverage through the federally facilitated (FFM) and state-based marketplaces (SBM) during the 2015 open enrollment period (November 15, 2014 to February 15, 2015). More than 8.8 million of these individuals were selected or were automatically re-enrolled in plans through marketplaces in the 37 states that are using the HealthCare.gov platform this year.

What is not particularly clear is how many of these enrollees have begun accessing health care services now that insurance coverage has been made available. Whatever increase in utilization may be involved, it seems reasonable to assume that the health workforce has not grown correspondingly. Additions to the workload have the potential to contribute to burnout among workers, which can affect the quality of care administered.

Another development in recent years is that an increased emphasis is being placed on the importance of interprofessional education and clinical training. All around the nation, efforts are underway in academic institutions to foster interaction among students from different professions, providing them with opportunities to understand and appreciate the unique contributions that each profession has to offer in the care of patients.

As in any occupation, it is not uncommon for a group of workers to have a specific vocabulary all their own. For example, both the military and government bureaucracies have been effective in producing extensive lists of acronyms used to describe their respective operations. Along with those short-hand ways of writing and speaking, another type of communication goes by the name of *slang*. Its use can serve different functions, such as reinforcing bonds among workers through the creation of their own subculture.

Slang also has its use in the form of dark humor. When experiencing unpleasant forms of pressure, sometimes the only effective coping mechanism is to find a way to laugh at different situations. During a busy night in the emergency room, "Code Brown" might be used to describe an incident of fecal incontinence. Wild and loud patients who overused drugs or alcohol and mentally unstable patients have the ability to generate invectives that are shared among caregivers.

It also is possible that members of one health profession may find it humorous to deride the capabilities of another health profession in team-oriented activities. The risk is that while negative assessments of co-workers may be beneficial in reducing stresses and strains for one group, the overall effect may prove to be counter-productive in achieving effective harmonious relations.

PRESIDENT'S MESSAGE

By Richard E. Oliver, ASAHP President

Our ASAHP 2015 Spring Meeting was held on March 19 & 20 in Myrtle Beach. We had a terrific line-up of speakers who provided a wealth of useful and thought provoking information.

Lee Foley, Capitol Hill Partners, provided some keen insight into the higher education agenda and the potential impact that policy changes will have on our educational institutions. He also emphasized the importance of ASAHP maintaining its advocacy efforts and having our voice heard by key legislators identified as being in positions of influence at the federal level.

Marshall Hill, Executive Director of the National Council for State Authorized Reciprocity Agreements (SARA,) provided an update on this voluntary national initiative to promote distance education and counter the very negative consequences of state authorization. Every ASAHP institution should visit the SARA web site www.nc-sara.org to determine if your state and your institution are SARA members. Membership can significantly reduce the costs associated with sending students out of state for clinical rotations if the receiving state is also a member of SARA.

Nikki Krawitz, former Vice President for Finance & Administration, University of Missouri System, provided a comprehensive overview of higher education budgeting and finance. A special emphasis was placed on the changing funding patterns in both public and private institutions, including declining state support and an increased reliance of student tuition income. Nikki is also a friend of ASAHP and has been very involved in our leadership program over the last several years.

Cheryl Miller, HealthSouth National Director of Therapy Operations, gave an overview of how health care reform is having an impact on health care delivery as well as clinical education. Particular attention was given to the need to better define the role of students while working with clinical preceptors and the implications to reimbursement. This is an area that ASAHP plans to stay involved with our industry partners.

Mark Sothmann, Vice President for Academic Affairs and Provost, Medical University of South Carolina, is also a former allied health dean and long-time friend of ASAHP. Mark shared his philosophy of leadership and talked about specific strategies he has employed over his career to promote trust, transparency and sound management principles as an academic leader.

Roy Anderson, Director, Center for Health Sciences Education, Cleveland Clinic, outlined the new procedures that are being employed by his institution to identify and evaluate all aspects of clinical education across their entire enterprise. This initiative was in response to the move to value-based care and the need to promote needed institutional efficiencies. In addition, educational partnerships and required practitioner competencies are being better defined to support this value-based culture. This too is an area that ASAHP plans to remain involved in as other institutions adopt similar practices.

Slides were used for most of these presentations and with the speaker's approval, will be posted on the ASAHP web site. We hope to have these available for above topics carried forward to future ASAHP meetings so that substantive work can continue to be accomplished.

As is our tradition, the Deans' Memorial Lecture and lunch was also held at this meeting. **Hugh Bonner**, Dean and Professor, of the College of Health Professions (CHP) at Upstate University in Syracuse, New York, shared his views on the changing nature of higher education and health care reform. His talk was extremely well received and reflected the insight he has gained over many years in higher education administration. Hugh has announced his retirement and will be moving with his wife, Lynnette, to Georgia to be closer to his children and avoid snow storms. We wish them good health and much happiness!

As you can see this proved to be an excellent conference and plans are now underway for our 2015 ASAHP Annual Conference to be held October 28 – 30, 2015 in Scottsdale, Arizona. The theme of this conference is "Innovations and Entrepreneurship in Health Care Education and Practice." So mark your calendars and watch for further details.

Best wishes as you begin to wind up the current academic year and prepare to send the next generation of health practitioners into the world! Rich

KEY INITIATIVES MOVE FORWARD IN CONGRESS

Committee leaders in the House of Representatives introduced bipartisan legislation in March to repeal the sustainable growth rate (SGR) formula. A major boost in achieving this outcome was provided by the support of Speaker of the House **John Boehner** (R-OH) and Minority Leader **Nancy Pelosi** (D-CA) who led negotiations in crafting the repeal legislation and expressed optimism that the proposal would have enough bipartisan support to pass this Congress. The "SGR Repeal and Medicare Provider Payment Modernization Act of 2015'' (H.R. 1470) would repeal the SGR and institute a 0.5 percent annual payment update for five years while a transition is underway to a new system.

Unless construction action of some kind is taken either through this proposed legislation or a short-term fix, physicians are scheduled to undergo a 21 percent reduction in payments on April 1. The past 17 years have been characterized by such short-term remedies. The deadline will be extended this year so that Senators can vote on the measure after they return from a two-week recess.

Other aspects of the bill include: incentivizing providers to receive at least 25 percent of their revenue through alternative payments models (APMs) by 2019 to 2020, with the threshold percentage of revenue increasing over time, requiring EHR interoperability by 2018, and extending funding for the Children's Health Insurance Program (CHIP) for two years. Senate leaders have expressed strong interest in moving a bill of this nature to the White House for President Obama's signature into law.

Both the House and Senate Republicans released budget proposals in March with the aim of balancing the federal budget within 10 years and doing so without any new tax increases. A common feature of both proposals is to repeal the Affordable Care Act. Another commonality is to repeal the Independent Payment Advisory Board (IPAB) The Senate plan also calls for a repeal of the 2.3 percent excise tax on medical device manufacturers.

Although more than 60 attempts have made by Republicans during the past five years to repeal the health reform law either in whole or in part, their efforts have not ended in success. The IPAB involves making coverage decision about the Medicare program that can be viewed as a usurpation of Congressional authority. The medical device tax is quite unpopular in states and congressional districts, which have companies that must pay this levy. Some Democrats are in favor of eliminating these two provisions.

During every session of Congress, other bills are introduced that could have an impact on either the health workforce or on allied health if enacted. For example, *S. 761* would amend the Public Health Service Act to designate certain medical facilities of the Department of Veterans Affairs as health professional shortage areas and *H.R. 1469* would improve, coordinate, and enhance rehabilitation research at the National Institutes of Health.

2015 ASSOCIATION CALENDAR OF EVENTS

March 19-20, 2015—Spring Meeting in Myrtle Beach, SC

June 3-4, 2015—ASAHP Board Meeting in Washington, DC

October 28-30, 2015— Annual Conference in Scottsdale, AZ

AFFORDABLE CARE ACT DEVELOPMENTS

After hearing oral arguments on March 4, the Supreme Court is expected to issue its ruling on the *King v. Burwell* case in June about the legality of providing health insurance premium subsidies to enrollees in the federal marketplace. If the justices decide in favor of the plaintiff, millions will lose the subsidy and as a result may not be able to afford coverage. Also, the decision could help to unravel the entire Affordable Care Act.

Although supporters of repeal might hail such an outcome, the fact remains that there will be a large number of exceptionally angry individuals who will have lost something that they formerly possessed. Republicans will be blamed. Consequently, some advance thought is being given to the role that the federal government might play to offset this prospect.

An example of an approach favored by some Republican Senators would be to provide financial assistance to enrollees currently receiving subsidies to enable them to keep their coverage for a transitional period, allowing states the freedom and flexibility to create better, more competitive health insurance markets offering more options and different choices. Under the proposal, even states not affected by *King v. Burwell* because they have their own state-based exchanges could adopt this new approach.

In March 2015, Senate Finance Committee Chairman Orrin Hatch (R-UT), Senator Richard Burr (R-NC) and House Energy and Commerce Committee Chairman Fred Upton (R-MI) unveiled the *Patient Choice, Affordability, Responsibility and Empowerment (CARE) Act*, which they say could replace the Affordable Care Act. Their legislation would repeal most ACA provisions (leaving Medicare reforms in place) and reinstate certain market reforms that would be modified. Their bill would:

- Prohibit lifetime dollar limits
- Limit the federal age rating to 5:1 (the limit is 3:1 under the ACA), although states could adopt different ratios
- Reinstate the age-26 requirement for adult children to remain on their parents' policies, but allow states to opt out
- Guarantee coverage renewal and prohibit rescissions (cancellations for fraud, misrepresentation or failure to pay premiums would be permitted)
- For those who are uninsured upon enactment, the lawmakers envision a one-time open enrollment period during which individuals could buy coverage regardless of health status or preexisting conditions. Tax credits would be available for employees of small companies and others without access to a group health plan, as well as those with incomes below 300% of the federal poverty level.

An examination of the data suggests that the premium tax credit offered via the Affordable Care Act boosted health care coverage in 2014. A Government Accountability Office (GAO) report released on March 23, 2015 found that the tax credit, which was intended to make premiums more affordable under the law, expanded coverage among uninsured, eligible beneficiaries by as much as 5 percent in 2014. The GAO looked at studies on insurance rates and interviewed experts from 11 research groups, as well as from the Department of Health & Human Services (HHS). The report found that the advanced premium tax credit reduced premiums by 76 percent from 2013 to 2014. Although data were not yet available for 2015, studies found the tax credit caused only modest changes between 2014 and 2015.

Most nonelderly adults had access to affordable health benefits plans as defined by the Affordable Care Act, but some may face challenges maintaining coverage. Most nonelderly adults had access to affordable plans through their employer, Medicaid, the exchanges, or other sources as of March 2014, although about 16 percent of nonelderly adults remained uninsured.

DEVELOPMENTS IN HIGHER EDUCATION

Republicans in the U.S. House of Representatives released a 2016 funding blueprint in March 2015 that calls for freezing the maximum Pell Grant award, a proposal that is expected to ignite a significant battle over the federal budget. Led by House Budget Committee Chairman, Representative Tom Price (R-GA), the result would be to maintain the maximum Pell award at the current $5,775 for the next 10 years. The freeze accords with an overall plan to achieve deep reductions in domestic spending as a means of bringing expenditures by the federal government into balance with its revenue over the next decade. The initiative is consistent with efforts made by Representative Paul Ryan (R-W)) when he served as Chairman of the Budget Committee during the previous Congress. An underlying objective is to restrict the awarding of Pell grants to students most in need of them instead of allowing individuals from families with higher amounts of income to be eligible.

The budget blueprint contains language that would make possible a parliamentary maneuver known as *reconciliation*, which is a procedural shortcut to change policies by a simple majority vote. Democrats used this strategy in 2010 to eliminate banks from the federal student lending system. When reconciliation is used to make changes in student financial assistance programs, it can have an impact on reauthorization of the Higher Education Act. For example, for changes that cannot be achieved through reconciliation because they do not have a direct effect on the budget, these matters might be left unattended.

The House Subcommittee on Higher Education and Workforce Training, which is chaired by Representative Virginia Foxx (R-NC) held a hearing on March 17 entitled, *"Strengthening America's Higher Education System."* Testimony was presented by:

Mitch Daniels, President of Purdue University

He stated the nation needs a reauthorization of the Higher Education Act that will: reduce the cost of higher education's regulatory burden; simplify and improve financial aid; and create an environment more conducive to innovation in higher education.

Christine Keller, Vice President of Research and Policy Analysis at the Association of Public and Land-Grant Universities

She indicated that reliable data are the foundation for any reporting system. Collected data should be as parsimonious as possible. Federal data collection should be minimized to focus on a few elements related to access, affordability, progress on completion, and post-collegiate outcomes.

David Bergeron, Vice President for Postsecondary Education Policy at the Center for American Progress

He called for the creation of a Public College Quality Impact to ensure that students have access to an affordable education and are able to earn credentials or degrees. Aid provided today must be repaid, but repayment would be based on the graduate's income primarily through wage withholding.

Michael Bennett, Associate Vice President Financial Assistance Services at St. Petersburg College

He stated that improving student financial aid and the experiences that students and families have with those programs will require a multi-faceted approach to simplification. A new repayment model could consist of two basic plans: one based on income and one standard 10-year repayment plan.

QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Ebola Incidence

Concerns about Ebola in the U.S. have abated since early reports dominated media coverage. As of March 17, the Centers for Disease Control and Prevention (CDC) reported 24,778 total cases (suspected, probable and confirmed). The problem has been confined primarily to outbreaks in West Africa. More than 10,000 deaths have been reported.

All Embracing Nature of Cancer

Cancer is an enormous global health burden, touching every region and socioeconomic level. Today, cancer accounts for about 1 in every 7 deaths worldwide – more than HIV/AIDS, tuberculosis, and malaria combined. In 2012, there were an estimated 14.1 million cases of cancer diagnosed around the world and 8.2 million cancer deaths. Moreover, the global cancer burden is growing at an alarming pace. In 2030 alone, about 21.7 million new cancer cases and 13.0 million cancer deaths are expected to occur, simply due to the growth and aging of the population. The Agency for Healthcare Research and Quality (AHRQ) estimates that the direct medical costs (total of all health care expenditures) for cancer in the U.S. in 2011 were $88.7 billion. Half of this cost is for hospital outpatient or office-based provider visits, 35% is for inpatient hospital stays, and 11% is for prescription medications.

HEALTH TECHNOLOGY CORNER

Using Shipping Containers In The Battle Against Ebola

As a means of combating Ebola, the U.S. Agency for International Development (USAID) hosted a competition to generate innovative ideas. A Baylor College of Medicine team was provided with funding for its proposal to *Build an Emergency Smart Pod (ESP),* a mobile, eight-bed clinic built from a used shipping container. Each ESP unit would contain eight beds, an air filtration system, air conditioning, and a contained waste management system. The pod also has clinical training apps to explain how to use the ESP properly. An advantage is that ESPs can be constructed for quick deployment to disease-stricken areas, which compares favorably to building a stand-alone hospital. Not only would the latter require nine to 12 months to create, the cost might be 10 to 20 times higher. Not only can an ESP operate from an electric grid using solar panels, another attractive feature is that an eight-bed unit quickly can be converted to a 16-bed unit and individual units can be attached for waste management. Apart from Ebola, ESPs have the potential to be used as a rapid response for other kinds of epidemics and natural disasters in areas where electric power and a necessary infrastructure are lacking.

3D Printing And Health Care

Regular 3D printing is slow, mechanically weak, and the choices of material are far too limited. Chemist Joseph DeSimone and fellow scientists at the University of North Carolina are developing a new kind of printing technology called “continuous liquid interface production,” which uses light and oxygen to “grow” objects from a liquid, rather than adding layers on top of layers. Working 25 to 100 times faster than other 3D printers, this technology creates a smooth surface finish from biodegradable materials that can be highly elastic and created at a much faster rate than with traditional printer technology. By employing continuous liquid interface production, print speeds can be converted from hours to minutes. When this technology is combined with the Internet, making a blueprint of any product becomes potentially accessible. One outcome is that 3D printing can be integrated with tissue engineering and regenerative medicine. Other potential applications include: sustained delivery of antibiotic and chemotherapeutic drugs, designing stents for patients in emergency cardiac situations, and digital dentistry.

AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Litigation Update: The Affordable Care Act

In the five years since Congress passed and President Barack Obama signed into law the Affordable Care Act of 2010, the validity of the law has been litigated in federal courts throughout the United States. From infringements on religious liberty to violations of the legislative process, lawsuits challenging the ACA have reflected the dissatisfaction of many with both the substance of the bill and its implementation. A summary of major pieces of litigation appears in a report from the National Center for Policy Analysis. Some challenges have fared better than others, while other cases continue to wend their way through the court system. A Supreme Court ruling on the case of *King v. Burwell* is expected in June when it will be decided if the provision of premium subsidies to enrollees in the federal marketplace is legal. The report can be accessed at http://www.ncpa.org/pdfs/bg176.pdf.

County Health Rankings

The 2015 *County Health Rankings* show that premature deaths are dropping, with 60 percent of the nation's counties seeing declines. For instance, in the District of Columbia premature death rates have plummeted by nearly one-third based on data from 2004-2006 and 2010-2012, marking the highest drop in the country for counties with populations of 65,000 or more. For many counties these rates are not improving—forty percent of counties are not making progress in reducing premature deaths. A rich resource of local-level data, the *Rankings* are an easy-to-use snapshot comparing the health of nearly every county in the nation. A collaboration between the Robert Wood Johnson Foundation (RWJF) and the University of Wisconsin Population Health Institute, the *Rankings* allow each state to see how its counties compare on 30 factors that impact health, including education, transportation, housing, violent crime, jobs, diet and exercise. The *Rankings* can be accessed at http://www.countyhealthrankings.org/

Impact Assessment of Quality Measures Report

The Centers for Medicare and Medicaid Services (CMS) issued its *2015 National Impact Assessment of Quality Measures Report*. It is a comprehensive assessment of quality measures that examines the effectiveness and impact of measurement and demonstrates a commitment to achieving optimal results from CMS quality measurement programs. Specifically, the report outlines the performance on quality measures over time and improvements achieved. Findings include research on 25 CMS quality programs and hundreds of quality measures from 2006 to 2013 and builds on the prior 2012 Impact Assessment Report. Many measures also are included in incentive programs that link payment to quality performance. The report can be accessed at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Downloads/2015-National-Impact-Assessment-Report.pdf

Gates Foundation Issues Report On Higher Education Policy

In a new report, the Bill & Melinda Gates Foundation has laid out what it thinks should happen in four key areas of higher education policy. The report describes a focus on data and information; finance and financial aid; college readiness; and innovation and scale. The report can be accessed at http://postsecondary.gatesfoundation.org/wp-content/uploads/2015/03/PS-ADV-Priorities-V1.pdf.

HOSPITALS AND HEALTH CARE

In 2013, America's hospitals treated 134 million patients in their emergency departments, provided care for 544 million other outpatients, performed nearly 27 million surgeries, and delivered nearly 4 million babies. A report on March 3, 2015 from the American Hospital Association (AHA) indicates that America's community hospitals contributed nearly $2.6 trillion to the U.S. economy in 2013, including 5.6 million jobs. Hospitals are the second largest source of private-sector jobs, accounting for one of nine jobs with ripple effects included. Each hospital job supports about two more jobs in other sectors and every dollar spent by a hospital supports roughly $2.30 of additional business activity, the analysis shows. The AHA conducts an annual survey of these facilities in the United States. The data below from the 2013 AHA Annual Survey are a sample of what can be found in the *AHA Hospital Statistics 2015 Edition*:

Total Number of All U.S. Registered * Hospitals 5,686
Number of U.S. Community ** Hospitals 4,974
Number of Nongovernment Not-for-Profit Community Hospitals 2,904
Number of Investor-Owned (For-Profit) Community Hospitals 1,060
Number of State and Local Government Community Hospitals 1,010
Number of Federal Government Hospitals 213
Number of Nonfederal Psychiatric Hospitals 406
Number of Nonfederal Long Term Care Hospitals 81
Number of Hospital Units of Institutions
(Prison Hospitals, College Infirmaries, Etc.) 12
Total Staffed Beds in All U.S. Registered * Hospitals 914,513
Staffed Beds in Community** Hospitals 795,603
Total Admissions in All U.S. Registered * Hospitals 35,416,020
Admissions in Community** Hospitals 33,609,083
Total Expenses for All U.S. Registered * Hospitals $859,419,233,000
Expenses for Community** Hospitals $782,035,350,00
Number of Rural Community Hospitals 1,971**
Number of Urban Community Hospitals 3,003**
Number of Community Hospitals in a System * 3,144**
Number of Community Hospitals in a Network ** 1,582**

*Registered hospitals are those hospitals that meet AHA's criteria for registration as a hospital facility. Registered hospitals include AHA member hospitals as well as nonmember hospitals.
**Community hospitals are defined as all nonfederal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services. Community hospitals include academic medical centers or other teaching hospitals if they are nonfederal short-term hospitals. Excluded are hospitals not accessible by the general public, such as prison hospitals or college infirmaries.
***System is defined by AHA as either a multihospital or a diversified single hospital system. A multihospital system is two or more hospitals owned, leased, sponsored, or contract managed by a central organization. Single, freestanding hospitals may be categorized as a system by bringing into membership three or more, and at least 25 percent, of their owned or leased non-hospital preacute or postacute health care organizations. System affiliation does not preclude network participation.
**** Network is a group of hospitals, physicians, other providers, insurers and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community. Network participation does not preclude system affiliation.