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**ASSOCIATION OF SCHOOLS OF  
ALLIED HEALTH PROFESSIONS***Vanguard of  
Allied Health Education*

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## ANIMAL KINGDOM CO-DEPENDENTS

The philosopher Plato sought to distinguish human beings by defining them as featherless bipeds (the definition subsequently had to be expanded when the skeptic Diogenes indicated that a newly plucked chicken also would have to be classified as such). Our species tends to view its members as the measure of all important matters, yet a case might be made about the definite relevance of a key co-dependency that exists with other inhabitants of the animal kingdom.

Investigations aimed at improving the health status of humans often rely on clinical experiments conducted on mice. The injection of cancer cells into these small creatures has led to a finding that vigorous physical exercise produces epinephrine and interleukin-6 that mobilize natural killer cells. Given that frail individuals may be unable to engage in high energy physical activity, the possibility might exist of someday injecting these substances into humans as a way to prevent tumor growth.

If there is any downside to these kinds of developments, however, it is in how they are reported in the media. All too often, highly inflated language creates an impression that millions of lives can be saved, but critical information frequently is excluded. Humans are not 195-pound mice and the road from initial prediction to final approval by the U.S. Food and Drug Administration can be a long one indeed.

Although some experts in the mid-20<sup>th</sup> century declared that an era of infectious disease had drawn to a close, their optimism proved to be rather short-lived. Cross-species transmission of fatal diseases is a common occurrence, with Zika being the most recent example. An earlier forerunner is the deadly impact of the Ebola virus on humans. More than half of the 1,400 known human pathogens stem from pigs, bats, chickens, and other animals.

Much emphasis is placed today on the importance of translational medicine, but as noted in the September 2, 2015 issue of the journal *Science Translational Medicine*, even as spontaneous animal models of human diseases merge into the mainstream of translational medicine, traditional boundaries in the biomedical literature—peer-reviewed journals and their knowledge domains—continue to reinforce separation between animal and human health by demarcating species-specific contexts for organizing, retrieving, citing, and publishing. Veterinary medicine offers clinically relevant large animal models for a wide range of diseases and treatments in humans, from diabetes in cats to stem cell therapy in horses. Non-Hodgkin's lymphoma, for example, is one of the most common cancers affecting humans and dogs. Its diagnosis, molecular characterization, and treatment have been greatly enriched and advanced by comparative translational research.

The importance of interprofessional education in health care is well acknowledged. When veterinary medicine has a presence on a campus, it is worth pondering the extent to which its representatives should be included in discussions to broaden an understanding of disease and the most effective ways of treating it.

## PERSPECTIVE FROM THE PRESIDENT'S CORNER

By Linda Petrosino, ASAHP President



It was a pleasure to see so many of our members benefit from the recent informative and thought provoking Spring Meeting held in Louisville. Not everyone was able to attend and it is worth providing a recap of the tremendously strong program. Immediately prior to the start of the Meeting, the *ASAHP Leadership Development Program (LDP)* was offered for two full days to eleven participants. The LDP was chaired by **Sharon Stewart** (University of Kentucky) and assisted by **Phyllis King** (University of Wisconsin—Milwaukee), **David Shelledy** (University of Texas Health Science Center-San Antonio), **Andrew Butler** (Georgia State University), **Chris Bradberry** (Creighton University), and **Peggy Valentine** (Winston-Salem State University). The Spring Meeting opened with **Andy Garman**, CEO for the National Center for Health Care Leadership, providing insights into leadership and the future of health care. **Lee Foley**, Managing Partner, Capital Hill Partners provided an understanding of what to expect in federal policy in higher education and what it means for allied health.

**Karen Miller**, former dean and senior vice chancellor for Academic and Student Affairs, University of Kansas Medical Center was the keynote speaker for the *Deans' Memorial Lecture* and she artfully and pragmatically addressed successful characteristics of leadership. **Kent Wallace**, Executive VP and COO, Kindred Health Care provided a view from the employer's perspective of our graduates. A Research Panel facilitated by **Chris Ingersoll**, (University of Toledo) spoke about preparing allied health faculty to compete for federal research grants. **Je'Mone Smith**, Divisional Vice President of Human Resource and Diversity, Kindred Health Care provided a timely presentation regarding diversity and inclusion in the health care workforce, and a 3-person panel reacted to the session providing insight from various perspectives. A great reception hosted and sponsored by Kindred Health Care provided a St. Patrick Day's theme in the Atrium of the Kindred Support Center. Food, drink and fun were plentiful and provided the perfect environment for networking, reconnection of friendships, and the establishment of new friendships. As I summarize the Meeting, I am reminded of the success of this venue in meeting the objective of speaking to the future for allied health education, practice and diversity. I thank **Ruth Welborn** for chairing the planning committee responsible for putting together the program.

Since this communication is focused on ASAHP's recent Meeting I take this opportunity to address the need to periodically reflect on the why's, what's and when's of our offerings. Twenty five to thirty years ago, conferences were in place primarily to disseminate a large amount of information that was difficult to get elsewhere and to also allow people to network and get to know each other. For over 30 years, ASAHP has offered a Spring Meeting (1 ½ days) and a fall Annual Conference (2 ½ days). Today, most information can easily be obtained elsewhere or through different channels; networking can, and is done, through social media; and relationships can be built across a distance. Do we have the why's, the what's and the when's still correct? Do we need to continue to offer a short Spring Meeting that attracts an average of 80 attendees along with the annual conference that attracts on average 220 attendees?

Do we eliminate the Spring Meeting and build a 3-day Annual Conference with robust informational sessions, interactive sessions and more networking relationship building time? We always need to take time to reflect on what we do as an organization and to determine if we continue to serve the needs of our membership in the most effective and resource efficient manner. As such, we are taking time to think about the offering of the annual Spring Meeting and the annual Fall Conference. We have had this conversation periodically and believe it is time to once again ask the questions. Please help us make the best decision as we go forward. A very short survey will soon be sent out to our members to solicit your thoughts on the continuation or the elimination of the Spring Meeting. We value the input of our members and look forward to your thoughts.

Best to all as you finish up the academic year and look forward to the end of the year celebrations!

Linda Petrosino



## CONGRESS STARTS TO ADDRESS SPENDING

Congressional activity was interrupted at the end of March by the beginning of a two-week recess. Prior to adjourning for that period, appropriators in the House of Representatives marked up the 2017 spending measure for the Department of Veterans' Affairs and military construction projects. The bill is in accord with spending limits contained in the budget agreement that was forged in 2015. The House is scheduled to be back in session on April 11. The Senate starts up again on April 4.

Proposed spending measures usually prove to be quite nettlesome to resolve each year. Lurking in the wings is an ongoing concern expressed by many legislators about the growing national debt. Apart from the steady increase in entitlement spending occasioned in part by the addition of more older Americans enrolled in the Medicare and Social Security programs, paying interest on that debt continue to be a major federal expenditure. Although there have been successful efforts to reduce the budget deficit each year, the overall deficit continues to grow.

It is within this backdrop that many debates continue regarding how much the government should be obligating itself to spend annually. An example is that members of the conservative House Freedom Caucus continue to oppose the Republican budget resolution on account of the budget deal's \$1.07 trillion discretionary spending limit. The group prefers that the resolution revert back to the previous spending caps of \$1.04 trillion.

The usual pattern that occurs is that no appropriations bills are brought to the House floor until both chambers have adopted a budget resolution conference report. An alternative would be for the House to pass a deeming resolution with a simple majority vote, containing an enforceable spending top line. In the event an agreement cannot be reached on either an adopted budget or a deeming resolution, the House may begin considering bills on the floor after May 15.

The aforementioned Military-Construction-Veterans Affairs draft-spending bill for fiscal year 2017 was released by House appropriators in late March and adopted by the subcommittee by voice vote. The \$81.6 billion bill exceeds current spending levels by \$1.8 billion, but is less than the Obama Administration's budget request of \$82.8 billion. The bill is in keeping with the budget deal's top line spending limits. The Department of Veterans Affairs would receive \$73.5 billion, a three percent increase above FY 2016. The bill also includes \$260 million to update the VA's electronic health record (EHR) system and \$850 million in additional funding for the purposes of veteran health care needs, including the treatment of hepatitis C and long-term care.

### 2016 ASSOCIATION CALENDAR OF EVENTS

**October 17-18, 2016**—Leadership Development Program in New Orleans, LA—Part II

**October 19-21, 2016**—Annual Conference in New Orleans, LA

Note: Efforts are underway to identify future conference locations

## AFFORDABLE CARE ACT DEVELOPMENTS

### **Medicaid Expansion And Patient Access To Health Care**

The Affordable Care Act stimulated an expansion of the Medicaid program in many states across the nation. An *Analysis in Brief* from the Association of American Medical Colleges (AAMC) reports on how consumers' access to health care has changed in the period leading up to and following the implementation of this expansion and insurance exchanges in January 2014 and examines the variations in access to care that persist. Recent changes in U.S. health care policy were designed to increase access to health care services, especially among low-and middle-income individuals. Although there is evidence that more Americans are obtaining health insurance, the results suggest no overall improvement. Unfortunately, a disproportionate share of individuals from traditionally underserved population groups continues to face barriers to care, yet these barriers may be shifting such that fewer cite cost of care as the primary reason they could not access care and more cite difficulty finding a provider.

This situation may reflect the greater affordability of health care as more Americans obtain health insurance. The newly insured may be only slightly better able to access care, often delayed care, possibly because of the limited availability of providers to meet the surge in demand. Despite improvements in insurance coverage and affordability of care, millions of Americans continue to experience barriers to health care and these barriers may be changing with time. In particular, more consumers are having trouble finding a provider. Health care coverage expansion is an important step toward improved access to care, but it does not ensure that all Americans have equal access to the care they need when they need it. Future research should account for the interplay of factors affecting health care availability through multivariable models.

### **Strengthening Enrollment Controls And Managing Fraud Risk**

The Government Accountability Office (GAO), the Congressional watchdog agency, issued a report on March 17, 2016 to determine what the Centers for Medicare & Medicaid Services (CMS) is doing to strengthen enrollment controls and manage fraud risk regarding the Affordable Care Act. The reform law requires applicant information be verified to determine eligibility for enrollment or income-based subsidies. To implement this verification process, CMS created an electronic system called the "data services hub" (data hub), which, among other features, provides a single link to federal sources, such as the Internal Revenue Service and the Social Security Administration, to verify consumer application information. Although the data hub plays a key role in the eligibility and enrollment process, CMS does not, according to agency officials, track or analyze aggregate outcomes of data hub queries, either the extent to which a responding agency delivers information responsive to a request, or whether an agency reports that information was not available. In not doing so, CMS foregoes information that could suggest potential program issues or potential vulnerabilities to fraud as well as information that might be useful for enhancing program management.

The law also establishes a process to resolve "inconsistencies," instances where individual applicant information does not match information from marketplace data sources. GAO found CMS did not have an effective process for resolving inconsistencies for individual applicants for the federal Health Insurance Marketplace (Marketplace). For example, according to GAO analysis of CMS data, about 431,000 applications from the 2014 enrollment period, with about \$1.7 billion in associated subsidies for 2014, still had unresolved inconsistencies as of April 2015, several months after close of the coverage year. CMS also did not resolve Social Security number inconsistencies for about 35,000 applications (with about \$154 million in associated subsidies) or incarceration inconsistencies for about 22,000 applications (with about \$68 million in associated subsidies). With unresolved inconsistencies, CMS is at risk of granting eligibility to, and making subsidy payments on behalf of, individuals who are ineligible to enroll in qualified health plans.

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## DEVELOPMENTS IN HIGHER EDUCATION

### **State Authorization Reciprocity Agreement (SARA)**

An issue of considerable importance to ASAHP member institutions is the regulatory burden on colleges and universities that wish to offer online programs in states other than the one in which they are physically located. The following information was obtained from an article that appeared on March 21 in the online publication *Inside Higher Ed*.

Prior to the creation of the State Authorization Reciprocity Agreement (SARA), institutions had to apply in each individual state, a lengthy process that could cost hundreds of thousands of dollars and even discourage some institutions from enrolling students in certain states. As states join SARA, they agree to a common regulatory framework. Colleges and universities then apply to join SARA, paying no more than \$6,000 a year to be approved to offer online education in every member state. SARA signed up its first state, Indiana, in February 2014. By the end of the year, 17 more states had joined. Currently, the initiative has 36 members and most of the remaining states, along with the District of Columbia and Puerto Rico, are making progress toward joining.

An item added to the *NewsWire* section of ASAHP's homepage on March 21 describes a letter signed by more than 30 leading consumer protection and legal services organizations that was sent to the New York State Education Commissioner for the purpose of expressing concerns about New York signing onto the State Authorization Reciprocity Agreement (SARA). The rationale is that while SARA could certainly benefit reputable in-state schools, it also inadvertently exposes New Yorkers to predatory colleges and online scams by ceding the state's regulatory authority.

Marshall A. Hill, executive director of SARA's national council, said "There is nothing in SARA that reduces the ability of a state attorney general to go after misbehaving institutions that break state consumer protection laws -- absolutely nothing. SARA provides good state-level oversight for institutions of all types that deliver cross-state distance education." SARA has 674 members in total, about 40 of which are for-profit institutions. The rest are public or private nonprofits.

### **Refuting The "Bennett Hypothesis" Regarding Why Tuition Increases Occur**

William J. Bennett, former Secretary of Education, stated in a New York Times Op-Ed on February 18, 1987 that "if anything, increases in financial aid in recent years have enabled colleges and universities blithely to raise their tuitions, confident that Federal loan subsidies would help cushion the increase. In 1978, subsidies became available to a greatly expanded number of students. In 1980, college tuitions began rising year after year at a rate that exceeded inflation. Federal student aid policies do not cause college price inflation, but there is little doubt that they help make it possible." Subsequently referred to as the "Bennett Hypothesis," according to a report released on March 21, 2016 by the American Council on Education (ACE), this claim continues to exert a powerful effect on the national discussion about financial aid policy.

Instead, an argument is made in the report that the Bennett Hypothesis largely misses a much broader question which is, how do changes in aid policy affect the well-being of students who receive grant and loan assistance from the government, given that students often receive various forms of aid from the institutions they attend? A simple framework is used to show how some institutions have the capacity to siphon off a portion of any federal subsidy without changing their list price tuition. They can do so because the aid system allows institutions to decide their own aid allocations after they know a student's federal support package. Colleges and universities that give need-based grants can allow federal grant aid to displace some portion of their own internal funding. This displacement is more likely at nonprofit institutions that offer substantial amounts of need-based grant aid.

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

### **Slow Growth In Medicare Health Spending**

An *Issue Brief* released by the Department of Health & Human Services on March 22, 2016 indicates that Federal programs, such as Medicare, have benefitted from a sustained period of slow growth. Medicare spent \$473.1 billion less on personal health care expenditures between 2009 and 2014 than would have been spent if the 2000-2008 average growth rate had continued through 2014. Medicare could spend approximately \$648.6 billion less on personal health spending between 2009 and 2015 than would have been spent if the 2000-2008 average growth rate had continued if per enrollee spending growth continues to be low as current data suggest, at approximately 1.1 percent. To place this matter in context, the reduction in spending is greater than all of Medicare's spending for personal health care expenditures in 2015.

### **Infant Mortality Rate Disparities**

According to the *2015 National Healthcare Quality and Disparities Report, Chartbook on Health Care for Blacks*, the infant mortality rate continued to be significantly higher among black infants (10.9 per thousand) than white infants (5.1 per thousand) in 2012, although this gap is narrowing. Black infants (260.7 per 100,000 live births) are 3.5 times as likely to die as white infants (74.4 per 100,000 live births) due to complications related to low birth weight. Blacks had more than twice the rate of sudden unexpected infant death as whites (171.8 compared with 84.4 per 100,000 live births). Trends worth noting: From 2003 to 2012, the overall rate decreased from 6.8 per 1,000 live births to 6.0. The rate of infant mortality per 1,000 live births decreased overall and among all racial groups.

## HEALTH TECHNOLOGY CORNER

### **Predicting Hospital Readmission For Heart Failure Patients**

A new study from the Cleveland Clinic demonstrates that an at-home vitals monitor placed under the mattress can predict hospital readmission for heart failure patients effectively. The monitor tracks respiration rate, heart rate, and motion. This finding could be a step forward in encouraging care continuum from the hospital into the home. The sensors are non-invasive and can detect adverse events to allow for intervention prior to hospitalization. The study showed that change in respiratory rate is an effective predictor of hospital admission for patients with heart failure. Patients who were readmitted to the hospital had higher average heart and respiration rates and more respiration variability.

### **Consumer Readiness For Technology-Enabled Home Health Care**

As technology-enabled home health becomes more pervasive, how will consumers respond? What concerns and reservations will they have? Will they readily adopt new technologies? Deloitte conducted focus group research to better understand consumer expectations and preferences for receiving health care services in the future, focusing on care in the home. In general, consumers are optimistic: To them, the benefits of technology-enabled home health far outweigh the risks, and they are eager to try it. For the unwell, home health technology can help manage their conditions and slow disease progression. For caregivers, it can offer peace of mind. For the healthy, it can provide the tools and support to maintain healthy behaviors. Although interest is high, some concerns have been expressed. Consumers value the personal nature of health care and the patient-doctor relationship. Many are concerned that increasing reliance on technology will erode the relationships that they feel are already threatened by the fragmented nature of health care, decreasing face time with doctors, and difficulty establishing and maintaining those meaningful relationships. While it may seem obvious that technology should reinforce and facilitate relationships rather than supplant them, consumers' previous experiences with technology temper their enthusiasm.

## AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

### Lowering Health Care Costs By Fighting Chronic Diseases

Any effort to control health care spending will have to take aim at chronic disease. A *White Paper* released by the Partnership to Fight Chronic Disease indicates that about half of adults aged 45 to 64 have more than one chronic condition. Compared to an individual without any chronic conditions, spending is almost 2.5 times more for those with one chronic condition, six times more for patients with three chronic conditions, and 13.5 times more for patients with five or more chronic conditions. In order to reduce health care costs and economic losses resulting from poor health, the following steps are recommended: prioritize prevention and management of chronic conditions; encourage continued innovation in health care treatment and delivery; improve access to recommended care; promote health across generations; and replicate those programs that are working to promote wellness and manage disease. The white paper can be accessed at <http://www.fightchronicdisease.org/sites/default/files/PFCD%20White%20Paper%20-%20Final%20%281%29.pdf>.

### Medicare Payment Advisory Commission Report to Congress

The Medicare Payment Advisory Commission (MedPAC) released its March 2016 *Report to the Congress: Medicare Payment Policy*. In it, the commission offers proposals that would have an impact on inpatient rehabilitation facilities (IRFs), 340B drugs, and Medicare Advantage plans. MedPAC recommends that Congress direct the U.S. Department of Health and Human Services (HHS) to analyze the coding used to set payments for patients treated in IRFs. The analysis indicates that some of these specialty hospitals appear to categorize patients as more functionally disabled than they actually are. The Commission also recommends that HHS reduce Medicare payments for drugs purchased through the 340B discount program by 10% of the average sales price (ASP). The report goes on to recommend the development of a risk adjustment model that uses two-years of data from Medicare and Medicare Advantage plans in order to understand better the differences in the assessment of patient health in bill coding. The report can be accessed at [http://medpac.gov/documents/reports/Mar16\\_EntireReport.pdf](http://medpac.gov/documents/reports/Mar16_EntireReport.pdf).

### Communication With Health Providers

Among adults who reported having poor communication with their health providers in 2012, Hispanics had the highest percentage (11 percent) followed by blacks (10 percent) and whites (7 percent). This information appears in a report from the Agency for Healthcare Research and Quality entitled, *2014 National Healthcare Quality and Disparities Report, Chartbook for Hispanic Health Care*. The report can be accessed at <http://www.ahrq.gov/research/findings/nhqrdr/2014chartbooks/hispanichealth/index.html>

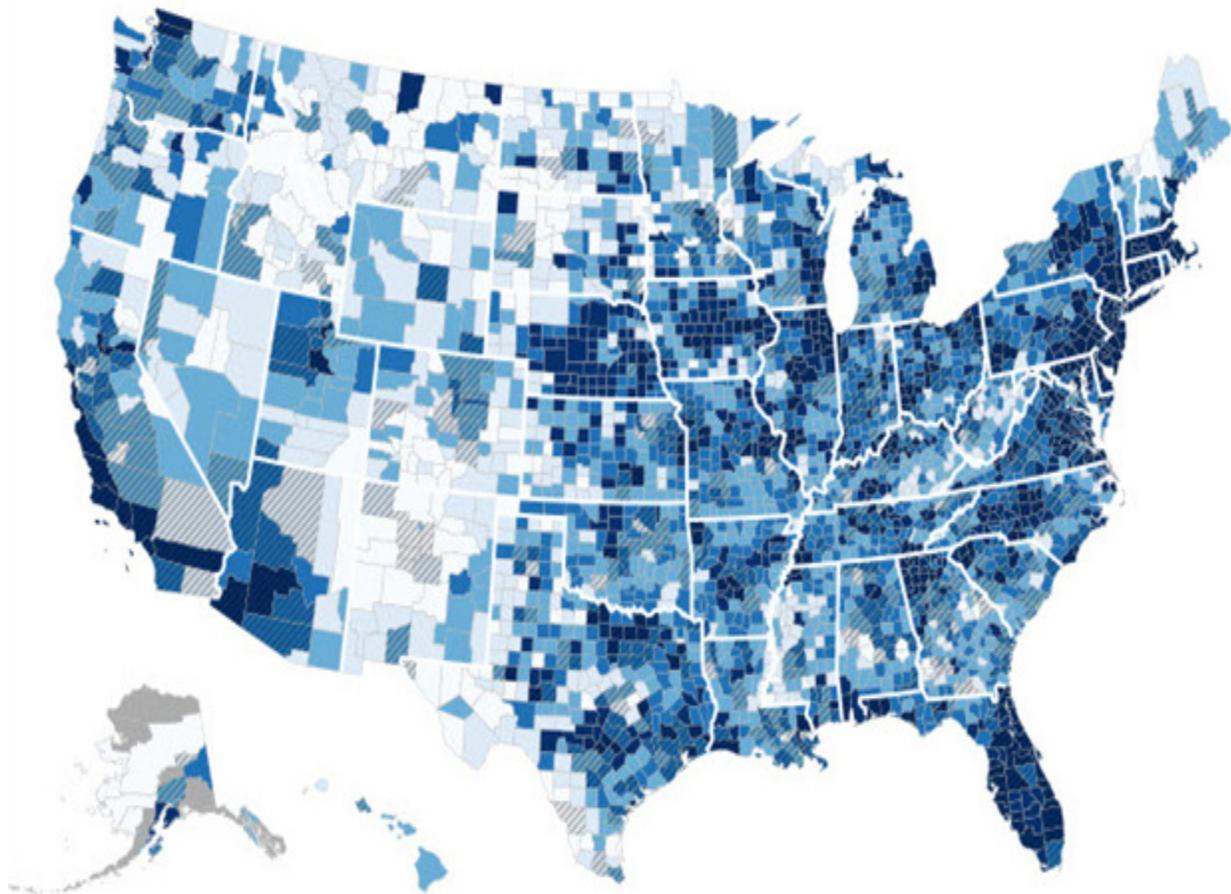
### External Barriers To Increased Hospital Data Exchange

According to a report from the American Hospital Association (AHA), hospitals are proactively developing the means to share information between departments as well as with other care partners, patients, and public health agencies. While access to data has increased, critical infrastructure and technical barriers constrain the sharing of patient information across settings of care. As a result, information sharing requires significant work and expense. Between 2010 and 2014, hospitals collectively spent hundreds of billions of dollars on their IT systems. The report can be accessed at <http://www.aha.org/research/reports/tw/16feb-tw-hitadoption.pdf>.

## MAPPING MEDICARE DISPARITIES

Chronic diseases pose a significant problem in the United States resulting in substantial morbidity, mortality, disability, and cost. The Centers for Medicare and Medicaid Services (CMS) Office of Minority Health has designed an interactive map, the *Mapping Medicare Disparities Tool*, to identify areas of disparities among subgroups of Medicare beneficiaries (e.g., racial and ethnic groups) in health outcomes, utilization, and spending. It is an excellent starting point to understand and investigate geographic and racial and ethnic differences in health outcomes. This information may be used to inform policy decisions and to target populations and geographies for potential interventions.

The *Mapping Medicare Disparities (MMD) Tool* contains health outcome measures for disease prevalence, costs, and hospitalization for 18 specific chronic conditions, emergency department utilization, readmissions rates, mortality and preventable hospitalizations. The MMD Tool provides a user friendly way to explore and better understand disparities in chronic diseases, and allows users to: 1) visualize health outcome measures at a national, state, or county level; 2) explore health outcome measures by age, race, ethnicity, and gender; 3) compare differences between two geographic locations (e.g., benchmark against the national average); and 4) compare differences between two racial and ethnic groups within the same geographic area.



The Mapping Medicare Disparities Tool can be accessed at <https://www.cms.gov/About-CMS/Agency-Information/OMH/OMH-Mapping-Medicare-Disparities.html>.