

TRENDS

Association of
Schools of
Allied Health
Professions

HIGHLIGHTS

MAY 2006

President's Message	2
Congress	3
Workforce Shortages	4
U.S. Migration Patterns	6
College Student Profiles	6
Available Resources	7
Board Actions	8



VANGUARD OF
ALLIED HEALTH EDUCATION

Trends is the official newsletter of the Association of Schools of Allied Health Professions (Suite 500, 1730 M St. NW, Washington, D.C., 20036, 202-293-4848) Trends is published monthly and available on the Association's website at www.asahp.org. For more information and/or subscriptions, contact the editor, Thomas W. Elwood, Dr.PH.

HEALTH CARE IN AMERICA

The front page story in the April issue of this newsletter contained a disheartening appraisal of health professions education from the standpoint of: workforce shortages in allied health, declining levels of financial support by the states for higher education, the high proportion of students entering college needing remediation, and the fact that only 25 percent of college graduates are deemed proficient in literacy. Apart from education, there is the broader perspective of health care and the news from that sector is equally as sobering.

Among Medicare beneficiaries who account for more than 75% of all U.S. health care expenditures, per capita spending varies by a factor of six between hospitals across the country. Average utilization and spending vary from state to state, from region to region within states, and from hospital to hospital within the same regions. Spending is not correlated with rates of illness in different parts of the country. Rather, it reflects how intensively certain resources - acute care hospital beds, specialist physician visits, tests and other services - are used in the management of patients who are quite ill.

The United States has fewer practicing physicians, practicing nurses, and acute care bed days per capita than the median country in the Organization for Economic Cooperation and Development (OECD). Nevertheless, U.S. health spending per capita is almost two and a half times the per capita health spending of the median OECD country. One proposal for both lowering health spending and improving quality is the adoption of health information technology (HIT). The United States lags by as many as a dozen years behind other industrialized countries in HIT adoption—countries where national governments have played major roles in establishing rules and health insurers have paid most of the costs.

The US spends considerably more on medical care (US \$5274 per capita) than in the United Kingdom (US \$2164 adjusting for purchasing power). Yet, Middle-aged Americans are less healthy than their English counterparts, according to a study from the RAND Corporation. The prevalence of diabetes was twice as high in the United States (12.5 percent) as compared to England (6.1 percent), while high blood pressure was about 10 percentage points higher in the United States than in England. Heart disease was 50 percent more common among middle-aged Americans than the English, while rates of stroke, lung disease, and cancer were higher among Americans as well. Based on the aforementioned considerations, it should be clear then that ample room exists for improvement, and working in conjunction with other key players, allied health has a role to play in the provision of effective, cost-efficient health care services.

PRESIDENTS'S MESSAGE

By David M. Gibson, ASAHP President



We are a country awash in technology. How many remote controls do we need in one room to operate a TV; how many are caught under chair or sofa cushions; which one operates the TV and which one is the remote control for the automatic gas fireplace insert? Walk down any street in any city and watch how many people are rushing hither and thither with cell phones glued to their ears. Watch drivers weaving in and out of traffic chatting away on their phones. I think we have become a people afraid of our own presence, our own solitude.

Now think about how technology has invaded patient care. Surely digital imaging has become a boon in diagnostic procedures, if not for patients then surely for GE and other medical imaging companies. In fact, the use of imaging technology use has risen over 25% in the past five or so years. It's the old saw: if you have the technology, use it. Has this increased use of diagnostic improved health outcomes? Perhaps, for some individuals but there are no definitive studies that suggest these aggressive diagnostic tools have improved public health. Most, if not all these technological advances hold great promise for more accurate diagnostic testing or therapeutic interventions. They also raise among scholars and religious leaders in many quarters, ethical issues that demand adjudication.

The flip side is that we may have technological tools in place, but fail to use them. Widespread use of electronic patient records is an example of an innovation that needs to be adopted on a grander scale. Instead, we have written records scattered among different physicians' offices and clinics. Even more revolutionary is the thought of having a microscopic chip implanted somewhere on our bodies that would contain all essential health information such as a listing of medical conditions, medications being used, and allergies. Today, a patient who collapses in a public place will be rushed to a hospital and without the benefit of such knowledge by caregivers, the aid that is administered might do more harm than good.

Telemedicine holds great potential for enhancing patient care, but a digital divide first must be overcome. Apart from owning a home computer to gain access to information, health illiteracy continues to be an obstacle in our country. For approximately 46 million Americans, their primary language is not English.

Technological developments will continue in areas such as genomics, nanomedicine, and stem cell research. Scientists currently are searching the human genome to identify new links between an individual's genetic makeup and their risk of becoming dependent on opioids. As genetic testing becomes a more commonly used diagnostic tool, however, the high cost of some procedures will result in adding just one more difference between the haves and the have nots in U.S. society.

Nanomedicine is at a stage where 50 nm nanodevices can enter cells in order to try and identify disease at the level of a single cell, target cells for drug delivery, and work with the body's own repair mechanisms. Toxicity and carcinogenicity challenges still have to be met. Health concerns include the possible harmful effects of the injection of such medicinal products into the human body and the excretion of non-biodegradable medical particles. Stem cell research is a topic that is as incendiary as abortion. Steps are being taken in various laboratories to overcome ethical objections through such techniques as (1) crippling a mouse embryo so that it can't form a placenta and attach to the uterus, and (2) plucking away a single cell from an eight-cell mouse embryo and using it to derive mouse embryonic stem cells. Ethicists debate whether these techniques overcome religious concerns. Technology has become an integral part of our lives. Harnessing it for the right purposes will continue to be a work in progress.



A CONGRESS AT ODDS WITH ITSELF

Most news accounts list President Bush's paltry approval ratings of 29% in recent polls, but rarely is mention made of the opinions that Americans have about Congress. The same poll conducted on May 5-8 that showed the President's low rating also revealed that only 18% of respondents gave Congress a favorable rating.

Now, accusations are being made that Democratic leaders are encouraging their members to refrain from working with Republicans on legislation. The theory being that some Republicans are in danger of losing their jobs come the November elections, so why give them a boost by letting them claim victories in the legislative arena. Toss in some criminal indictments directed at some House Members in recent weeks and it's not difficult to see why the electorate is somewhat less than total in its enthusiasm for lawmakers.

Producing a budget resolution each year and appropriations to match its contents are rancorous affairs. Given the growing preponderance of earmarks (also affectionately known as "pork") to fund pet projects, efforts to eliminate them is an uphill struggle. A proposal to delete 12 of more than 400 earmarks in the FY 2007 Agriculture appropriations bill crashed and burned with all amendments along such lines defeated. The bill itself passed on a vote of 378-6.

ASAHP and other organizations are trying to have Title VII funding restored to FY 2005 levels after they were cut by 52% for the current fiscal year. ASAHP members are encouraged to let their views be known, using the Association's website as a vehicle for contacting legislators and the media.

2006– 2007 ASSOCIATION CALENDAR OF EVENTS

October 16-17, 2006- Leadership Program- Millenium Knickerbocker Hotel- Chicago, IL

October 18-21, 2006 - Annual Conference- Millennium Knickerbocker Hotel- Chicago, IL.

October 18, 2006- Scholarship for Excellence winners announced.

March 15-16, 2007 Spring Meeting– St. Pete Beach, FL

October 17-20, 2007—Annual Conference—Catamaran Resort Hotel —San Diego, CA

ASAHP IN THE NEWS

During the past several weeks, ASAHP has been successful in placing an article in local newspapers about the importance of having an Allied Health Reinvestment Act passed by Congress. As of May 4, 92 publications with a readership of 1,007,392 have carried this article. While it is true that these are small town newspapers, many members of Congress hail from these same small locales and they all have clipping services to keep track of the kinds of information being disseminated to constituents by the media.

HOW WELL PREPARED ARE ALLIED HEALTH SCHOOLS TO MEET FUTURE WORKFORCE DEMAND?

*Stephen N. Collier, Ph.D., Director and Professor
Office of Health Professions Education and Workforce Development
School of Health Related Professions, University of Alabama at Birmingham*

When trying to determine workforce demand, one of the most commonly referred to sources is the U.S. Bureau of Labor Statistics (BLS). Every other year the Bureau publishes its employment outlook for a ten year period. In recent years, the BLS projections for health careers have been frequently cited since many of the health professions and occupations are among the fastest growing segments of the U.S. economy.

Several months ago BLS published its most recent employment outlook. Using employment statistics for 2004, projections have been made for 2014 (Daniel E. Hecker, "Employment Projections to 2014", *Monthly Labor Review*, November 2005). As with the reports from the more recent two year periods, the new projections continue to indicate strong growth in many of the health professions listed under the National Employment Matrix codes and titles 29 (health care practitioner and technical occupations) and 31 (healthcare support occupations). As a group, category 29 occupations are projected to grow 25.8% between 2004 and 2014, with category 31 occupations growing 33.3%. Most of the health professions found in ASAHP member schools are within the category 29 occupations.

With well known current workforce shortages in a number of fields, educators, employers, and higher education planners are looking to see what health professions programs should be created, expanded, sustained or reduced to meet the future needs of the U.S. population. Because of a scarcity of data and analysis when it comes to projecting the workforce requirements in the allied health professions, the BLS data have come to be a primary source in making changes to the supply of allied health professionals. However, most everyone recognizes there are important limitations to the BLS data and that projections ten years out pose some significant challenges regarding accuracy.

While the BLS data provide levels of current employment and an estimate of projected employment, it does not address the supply side of the workforce equation. Other sources, such as the National Center for Educational Statistics, individual professional associations or accreditation agencies, provide data regarding the number of graduates of allied health educational programs. Because the focus of most employers and educators is on the immediate needs in the workforce, little attention has been given beyond the short term to whether the supply of allied health professionals will meet the future employment demand.

To assess the longer term supply-demand picture, the table on the following page compares the BLS projections to 2014 with the recent rate of supply from accredited programs. There are many caveats regarding the data. The cumulative deficit or surplus displayed in the last column is based on a constant of the number of graduates in 2004 which is the most recent year for which data are available for most disciplines. Of course, the number of graduates will not remain at the 2004 levels, but will increase or decrease over time, with the past few years appearing to have enrollment increases in many disciplines. An illustration of this is in physical therapy where the 2004 graduates number 4,273, but where the projections of the American Physical Therapy Association indicate an expansion to 6,154 graduates by 2007—a substantial increase. On the other hand, due to program closures and reduced number of graduates in recent years, the picture for the Clinical Laboratory Scientist workforce is the reverse and an area of large concern. It appears a significant shortage is looming unless other factors come into play such as a changing nature of the work for these credentialed professionals or substitution by non-credentialed individuals, either of which could affect CLS employment demand.

ALLIED HEALTH EMPLOYMENT AND GRADUATES VERSUS WORKFORCE DEMAND

PROF	2000 ¹	2004 ²	2014 ²	% CHG 04-14 ²	AVG ANNUAL JOB OPENINGS 2004-2014 ^{2,3}	# GRADUATES 2004 ⁴	DEFICIT (-)OR SURPLUS (+) BY 2014
DH	147	158	226	43.3	8,200	4,925	-32,750
DMS	33	42	57	34.8	2,300	1,328	-9,720
D/N	49	50	59	18.3	2,200	2,771 ⁵	+5,710
CLS	148	156	188	20.5	7,400	1,998	-54,020
OT	78	92	123	33.6	4,300	2,970	-13,300
PT	132	155	211	36.7	7,200	4,273	-29,270
PA	58	62	93	49.6	4,000	3,676	-3,666
RT	167	182	224	23.2	7,600	8,404	+8,080
RTh	83	94	120	28.4	5,700	3,167	-25,330
SLP	88	96	110	14.6	3,800	NA ⁶	NA

Professions: DH dental hygiene, DMS diagnostic medical sonography, D/N dietetics and nutrition, CLS clinical laboratory science, OT occupational therapy, PT physical therapy, PA physician assistant, RT radiologic technology (radiography), RTh respiratory therapy, SLP speech language pathology.

¹⁻³ Numbers are in thousands of jobs. Source: Bureau of Labor Statistics, ¹“Occupational Employment Projections to 2010”, *Monthly Labor Review*, November 2001. ^{2&3} “Occupational Employment Projections to 2014”, *Monthly Labor Review*, November 2005. ³ Total job openings due to growth and net replacements 2004-2014, divided by 10 to arrive at annual average. ⁴ Source: *Health Professions Education Data Book 2005-2006*. American Medical Association.

⁵ Source: Annual Report 2005, Commission on Accreditation for Dietetics Education, p. 9.

⁶ Data not available. Most recent data from the Council of Academic Programs in Communication Sciences and Disorders is 2000-01.

The projections for other professions also create a more complicated picture than would be anticipated by looking at the figures in the last column. For example, the Physician Assistant profession is projected to grow by 49.6% between 2004 and 2014, but the cumulative shortage displayed is relatively small. A possible explanation for this is the growth of PA programs and number of graduates over the last five to ten years, added to the relatively young age of many of the graduates who can be expected to remain in the workforce for many years to come.

A significant consideration that may not be factored into the employment demand figures is the issue of third party reimbursement policy. This is particularly relevant for the rehabilitation professions. As was demonstrated by the Balanced Budget Act of 1997, changes in reimbursement policy can dramatically affect employment demand as well as student interest in programs.

Whether the shortages and surpluses shown in the last column of the table are representative of reality is an issue for debate. Certainly, the numbers can not be interpreted with any degree of preciseness, but they do indicate, at present, a general direction and magnitude that have to be taken into consideration.

Allied health educational programs will be created or modified based on current factors of supply and demand in local and regional geographic areas. It can be anticipated that normal market forces in supply and demand will have a large influence to which educational institutions will respond. However, because health professions programs are more expensive to conduct than many other types of programs, and because the funding picture for higher education is not an optimistic one for significant new resources, it may be difficult for educational institutions to effectively respond to market forces. Professional associations, educational institutions, and employers will each have to assess whether the above projections are realistic and present a warning like a canary in a coal mine, or whether the underlying assumptions in the BLS projections are unsound when it comes to the allied health professions and a different scenario is called for.

HIGHER EDUCATION AND U.S. MIGRATION PATTERNS

Migration is playing a larger role in population redistribution within the United States. With birth and death rates currently low and largely similar across the country, natural increase (the excess of births over deaths) exerts less influence than it used to in explaining why some regions, states, or counties have faster population growth than others. Population changes both in actual numbers and in percentages by age cohort exert a significant effect on the kinds and amounts of health services required. The educational system also is affected by these same factors from the standpoint of producing health professionals to fill available positions.

The migration story at this broad geographic level is one of net out-migration from the Northeast and the Midwest and net in-migration to the South. Within the Northeast, New England continued to experience net out-migration between 2000 and 2004, but at lower levels than during the 1990s. Within the West, net in-migration continued to the Mountain division and net out-migration occurred from the Pacific division; in both cases, these trends moderated from the 1990s' pace. The South continued to have the most net in-migration of any region, due to the continued higher levels of net in-migration to the South Atlantic division. Florida had the largest annualized amount of net in-migration during 2000–2004, averaging 191,000 per year (Figure 1). Arizona (66,000) and Nevada (51,000) were second and third, respectively. Of the 10 states with the largest annualized net migration amounts for the period, seven are located in the South and three are located in the West. Additional information may be obtained at <http://www.census.gov/prod/2006pubs/p25-1135.pdf>.

PROFILE OF U.S. COLLEGE STUDENTS

Twelve percent of all undergraduate students in the United States are first-generation Americans and 39 percent of undergraduates in the United States are aged 25 or older. These are just two of the fast facts offered in a new publication by the Center for Policy Analysis at the American Council on Education (ACE). *College Students Today: A National Portrait* uses data from the Department of Education's National Postsecondary Student Aid Study, 2003-04. It provides readers with statistics on the U.S. college student population including the percentage of male and female undergraduates, students of color, adult students, international students, low-income students, and undergraduates with foreign-born parents. It also includes useful data on graduate and professional students in the United States. Copies can be ordered on the Web at <http://www.acenet.edu/bookstore/pubInfo.cfm?pubID=365>.

COMMISSION ON THE FUTURE OF HIGHER EDUCATION

The *Commission on the Future of Higher Education* met in Washington, DC on May 18 and 19. Plans are underway to draft a final series of recommendations in a report due to be sent to Department of Education Secretary Margaret Spellings sometime in September. The commission is made up of representatives from higher education, business, and foundations. The group is examining ways to ensure that U.S. colleges and universities remain globally competitive and continue to meet the needs of students and families.

Accreditation is one of the topics addressed by the commission. A proposal has been offered to promote the establishment of a “National Accreditation Foundation” to take over the role of evaluating higher education institutions from private accrediting organizations. Critics of this approach maintain that it would be incompatible with a voluntary, autonomous, and self-regulatory system. Papers that were prepared for consideration by the commission may be obtained on the Web at <http://www.ed.gov/about/bdscomm/list/hiedfuture/reports.html>.

AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

ACCREDITORS' TRAINING WEBSITE

The information contained in this website was prepared through the collaborative effort of 15 accrediting agencies to provide an overview of the steps involved in accrediting academic programs at colleges, schools, and universities. It provides information and activities to help learn what is needed to participate on a site team or even prepare for an accreditation visit at one's institution. The content is presented in a format that broadly applies to many accrediting agencies. The website may be accessed at <http://www.acpe-accredit.org/edcenter/sitevisits/>.

2005 DIGEST OF EDUCATION STATISTICS

The Digest of Education Statistics provides a compilation of statistical information covering the broad field of American education from prekindergarten through graduate school. It includes a selection of data from many sources, both government and private, and draws especially on the results of surveys and activities carried out by the National Center for Education Statistics (NCES). The publication contains information on a variety of subjects in the field of education statistics, including the number of schools and colleges, teachers, enrollments, and graduates, in addition to educational attainment, finances, federal funds for education, libraries, and international education. Supplemental information on population trends, attitudes on education, education characteristics of the labor force, government finances, and economic trends provides background for evaluating education data. Portions of the report covering postsecondary education may be accessed on the Web at <http://nces.ed.gov/programs/digest/d05/lt3.asp#17>.

TRENDS IN HEALTH AND AGING

The National Center for Health Statistics (NCHS) has a site on the Web that contains tables on trends in the health of older Americans showing data by age, sex, race and Hispanic origin. The tables are easy to customize. The site may be accessed on the Web at <http://www.cdc.gov/nchs/agingact.htm>.

CASE STUDIES ON REDUCING HARM TO PATIENTS

A new report presents 10 case studies of health care organizations, clinical teams, and learning collaborations that have designed innovations in five areas that hold great promise for improving patient safety nationally: promoting an organizational culture of safety, improving teamwork and communication, enhancing rapid response to prevent heart attacks and other crises in the hospital, preventing health care-associated infections in the intensive care unit, and preventing adverse drug events throughout the hospital. Participating organizations ranged from large integrated delivery systems to small community hospitals. The cases describe the actions taken, results achieved, and lessons learned by these patient safety leaders, with suggestions for those seeking to replicate their successes. The study was supported by funding from The Commonwealth Fund. The report may be accessed on the Web at http://www.cmwf.org/usr_doc/McCarthy_safetycasestudies_923.pdf.



ASAHP President **David Gibson** and Immediate Past-President **David Gale** attended the annual meeting of the Consortium of Institutes of Higher Education in Health and Rehabilitation (COEHRE) in Setúbal, Portugal on April 19-22

BOARD ACTIONS

The following actions were among those taken during a conference call of the Association's Board of Directors on May 10, 2006:

- ◆ Approved the Minutes of the Board Meeting on March 14-15.
 - ◆ Agreed to contact professional associations to determine how ASAHP can best assist their efforts in responding to what medical organizations are undertaking to stop expanding scope of practice by allied health professionals in various States.
 - ◆ Discussed issues and concerns expressed by members regarding the mission of the Association and agreed to consider specific recommendations on how to improve the performance of ASAHP in addressing the needs and wishes of the membership. Upcoming deans' group meetings and the Annual Conference in Chicago next October will provide opportunities for additional discussion.
 - ◆ Approved a motion to provide a contact list to Associate Dean Charles Fox of Wichita State University so that he can conduct a survey of the ASAHP membership to determine what is being done in the area of ethics training in allied health programs.
 - ◆ Approved a motion to furnish \$5,000 from the Board's discretionary fund to serve as a sponsor of the FuturePoint Summit Meeting on June 15-16 in St. Louis.
 - ◆ Approved a motion to hold the 2008 ASAHP Annual Conference in Baltimore in conjunction with the National Network of Health Career Programs in Two-Year Colleges (NN2) and to plan one or two overlapping functions with that group. The two organizations did something similar in both 2001 and 2004.
-