

TRENDS

Association of
Schools of
Allied Health
Professions

HIGHLIGHTS

MAY 2007

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VANGUARD OF
ALLIED HEALTH EDUCATION

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LOCUS OF RESPONSIBILITY FOR DEALING WITH HEALTH WORKFORCE PROBLEMS

A new report from the Association of Academic Health Centers provides valuable information about actions by eight states in their respective efforts to cope with health workforce shortages. Each of these jurisdictions has produced different mechanisms for addressing issues that pertain to: the number and geographic distribution of licensed professionals, demographics of professions, vacancy rates in health care institutions, retention and turnover rates, trends in wages, inter- and intra-state migration of professionals, availability of educational programs within a state, and enrollment and graduation rates in health professions education programs.

A study of all 50 states undoubtedly would result in great variation in the capability to examine any of these factors that are instrumental in developing a comprehensive understanding of the nature of health workforce problems. Available resources would play a key role in determining to what extent a state could do what is necessary to collect the necessary workforce data and then be able to act appropriately on the basis of the information produced.

Since health personnel shortages represent a problem that is national in scope, surely there is a role for the federal government to play. Titles VII and VIII of the Public Health Service Act have been involved for several decades in health professions education activities. The *Section 755 Allied Health & Other Programs* under Title VII has provided funding for many innovative approaches to recruitment, retention, and curriculum improvements. The Workforce Investment Act has led to the establishment of state- and local-level Workforce Investment Boards (WIBs) in all 50 states. Career ladders and health career outreach initiatives have been created by some WIBs.

Each state and locales within states may have unique workforce problems. A top-down, one-size fits all approach does not represent a viable means of addressing personnel shortages. Pending legislation in Congress in the form of the Allied Health Reinvestment Act (S 605) is a proposed mechanism that would enable the federal government to provide resources that could be used effectively by the states, depending on the nature of the problems encountered.

One provision addresses the lack of allied health data. It would require the Health Resources and Services Administration (HRSA) to collect and consolidate allied health workforce data from federal agencies such as the Veterans Health Administration and the Centers for Medicare & Medicaid Services, along with state licensure data and data from professional associations to serve as a basis for developing useful profiles of various allied health professions.

PRESIDENTS' MESSAGE

By David M. Gibson, ASAHP President



“THERE IS NO CAUSE HALF SO SACRED AS THE CAUSE OF A PEOPLE. THERE IS NO IDEA SO UPLIFTING AS THE IDEA OF THE SERVICE OF HUMANITY.”

(WOODROW WILSON, GOVERNOR OF NEW JERSEY, PRESIDENTIAL CAMPAIGN ADDRESS, MADISON SQUARE GARDEN, NEW YORK CITY, OCTOBER 31, 1912. *THE PAPERS OF WOODROW WILSON*, ED. ARTHUR S. LINK, VOL. 25, P.498. 1978)

Congratulations to all of my colleagues as yet another academic year draws to an end and you have witnessed the fruits of your labors—graduates of your various allied health programs. In many cases, our graduates are second or even third career seekers and the opportunities that you and your faculties have afforded these new graduates constitute an often forgotten human service. From yet another perspective, as our graduates enter the health care workforce they have been prepared to deliver essential health care diagnostic, rehabilitative or therapeutic services, sometimes to those who can least afford these services. The very act of commencement is a renewal of faith in our youth and their very real desire to help others.

Despite the perceived glamour of being a dean or director, it is no easy job. Increasingly, we are held responsible for securing new sources of funds, even as many sources are waning. We are expected to increase enrollments with little or no additional resources; vie with other units within our colleges or universities for fiscal, human and special resources but remain a “team player.” Moreover, we are the Solomon-like arbitrators between our central administrations and our faculties; coaches between and among departments vying for attention, support and, of course, always additional resources which they believe we can readily obtain through some alchemistic cairns’ exsanguinations.

Of course, there are the countless and seemingly endless meetings during which I am sometimes reminded of Horace’s words: *montes laborant et nascitur ridiculus mus* (the mountains heaved in labor and gave birth to a tiny mouse)! We endure them because it is our responsibility to be listeners, to be separators of the wheat from the chaff, and to do so in a style that encourages dialogue and open exchanges of ideas.

We are, and should be, the penultimate advocates for students but also often are the last step in student disciplinary matters. We are also obligated to evaluate our faculty members’ performances, assess our programmatic outcomes, assure that school and university or college policies are followed, and probably even change light bulbs from time to time (a pleasant task because it is one of the few things we can do without convening a task force or committee).

So, at the end of the day what is so good about this job, this title? We build programs, we encourage faculty, we are participants in the life of higher learning and we shake hands with every graduate who crosses the stage or dais and we can see eyeball to eyeball their excitement, joy and anticipation of work in which they will be at the service of humanity. I am reminded of the line from Mel Brooks’ *History of the World: Part I*: “It’s good to be the king!” Well, congratulations colleagues, it good to be deans.

FEDERAL BUDGET AND APPROPRIATIONS



This month proved to be a busy one as Congress labored to produce a FY 2008 budget resolution and begin work on crafting 12 spending bills. A \$2.9 trillion budget resolution was adopted, but in a manner that is expected to lead to later quarrels over taxation, domestic spending, and how to deal with a large federal budget deficit. The House approved the measure by a vote of 214-209. Not a single Republican voted for it.

The vote in the Senate was 52-40, with Senators Snow and Collins from Maine being the only two Republicans on the winning side of the tally. The budget resolution sets an overall discretionary spending cap for FY 2008 of \$954.1 billion, but the amount does not include war spending. It also exceeds the budget proposed by the Bush Administration by \$23 billion. The budget resolution is non-binding and does not have to be signed into law by the President. Its importance lies in setting caps for discretionary spending. The Appropriations Committee in each chamber then divides the available money among the 12 subcommittees such as the one for the Departments of Labor, Health and Human Services, Education & Other Agencies, the Labor-HHS account. In three of the past five years, Congress moved appropriations bills forward in the absence of such a budget blueprint.

Typically, most spending bills fail to be enacted by the start of a new fiscal year each October 1. The year 2006 (FY 2007) ended with only two bills signed into law. The rest carried over to 2007 and were packaged into a continuing resolution that is in effect until September 30, the last day of FY 2007.

Appropriators are behind schedule already in their quest to complete all spending bills before the fiscal year draws to a close. Even if they complete their work in a timely fashion, the threat of one or more Presidential vetoes looms ahead. Mr. Bush has vetoed only two bills since occupying the Oval Office. The first occurred last year when a stem cell research bill was placed on his desk. The second item that failed to pass muster involved the coupling of spending for the war in Iraq with a timetable for withdrawing troops from that country.

He vows to act in a similar way if spending bills exceed his budget requests. Democrats can try some time-tested ways of avoiding his wrath. One would be to take the Labor-HHS bill, which usually is contentious over such issues as abortion or raising the minimum wage, and tying it to a war spending bill or merging Labor-HHS spending with other kinds of appropriations in omnibus legislation.

2007 ASSOCIATION CALENDAR OF EVENTS

October 15-16, 2007—Part II of the Leadership Development Program

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

March 13-14, 2008—Spring Meeting-TradeWinds Resort-St. Pete Beach FL

Sites have been selected for other upcoming ASAHP events. The 2008 Annual Conference will be held in Baltimore, MD in conjunction with the National Network of Health Career Programs in Two-Year Colleges. The conference in 2009 will be in San Antonio, TX and in Charlotte, NC in 2010.

COMPARATIVE INTERNATIONAL PERFORMANCE OF U.S. HEALTH CARE

Despite having the most costly health system in the world, the United States consistently underperforms on most dimensions of performance, relative to other countries. A report from The Commonwealth Fund—an update to two earlier editions—includes data from surveys of patients as well as information from primary care physicians about their medical practices and views of their countries' health systems. Compared with five other nations—Australia, Canada, Germany, New Zealand, the United Kingdom—the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity, and healthy lives. The U.S. is the only country in the study without universal health insurance coverage, partly accounting for its poor performance on access, equity, and health outcomes. The inclusion of physician survey data also shows the U.S. lagging in adoption of information technology and use of nurses to improve care coordination for the chronically ill.

The report may be accessed on the Web at http://www.commonwealthfund.org/usr_doc/Davis_mirrorinternationalupdate_1027.pdf?section=4039. A chart pack also can be accessed at http://www.commonwealthfund.org/usr_doc/Shea_hlt_sys_performance_selected_nations_chartpack.pdf?section=4039.

NOMINEES FOR 2007 ASAHP ELECTION

The next ASAHP election will be held in mid-July of this year. The following positions will be contested: **Secretary** (two-year term), *two seats* on the **Board of Directors** (three-year terms), and *three seats* on the **Nominations & Election Committee** (two-year terms). The candidates for these positions are as follows:

Secretary

Susan Hanrahan (Incumbent), Dean at Arkansas State University

Board of Directors

Andrew Balas, Dean at Old Dominion University

Barry Eckert, Dean at Armstrong Atlantic State University

Lori Stewart Gonzalez (Incumbent), Dean at University of Kentucky

Cynthia Hughes Harris (Incumbent), Dean at Florida A & M University

Diane Jacobs, Department Chairperson at University of Central Florida

Wendy Rheault, Dean at Rosalind Franklin University of Medicine & Science

Beverly Schmoll, Dean at Wayne State University

Richard Talbott, Dean at University of South Alabama

Ruth Welborn, Dean at Texas State University-San Marcos

Nominations & Elections Committee

Denise Heineman, Dean at Florida Gulf Coast University

Linda Petrosino, Dean at Bowling Green State University

William Siler, Assistant Dean at St. Louis University

Sharon Stewart, Associate Dean at University of Kentucky

This year's election marks the first time that the balloting will be conducted electronically. Instead of mailing ballots to the membership, information about and photos of the various candidates will be placed on the ASAHP website. In order to participate and have one's vote counted, membership dues must be paid by September 1, 2007. Dues invoices were mailed in early March. The results of the election will be made public in early September.

Trends Affecting Health Professions Education

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Educators in the health professions are, or should be, constantly seeking to identify current and future trends so they can make their programs more responsive to the needs of the public and their professions. Several of those trends will be briefly examined here with their implications for educational programs in ASAHP member institutions.

The health workforce shortage: local trumps national. Even though there is a national shortage of health professionals, what is important is knowing the local situation since the provision of health care is primarily a local market. There may be wide variance in personnel shortages from one locale to another. There will sometimes be significant differences not only from one state to another, but among sub-state regions and local areas as well.

In recent years a number of states have seen personnel vacancies reduced somewhat in hospital settings, where in other states the shortages have continued to increase. Whether these changes reflect some type of normal fluctuation or constitute a trend is open to interpretation. Since the largest health profession by far is nursing, and nurses are the largest group employed in hospitals, the focus is often on them. There may be wide variances in vacancy rates in other health professions, many of which are also found in ASAHP member institutions.

Percentage Vacancies in Hospitals

| | Ohio | | Maryland | | Missouri | |
|-----------------------|------|------|----------|------|----------|------|
| | 2005 | 2006 | 2004 | 2005 | 2005 | 2006 |
| REGISTERED NURSE | 5.7 | 5.1 | 9.2 | 10.0 | 9.5 | 7.5 |
| RADIOGRAPHER | 9.8 | 8.8 | 9.1 | 10.8 | 6.4 | 3.7 |
| PHYSICAL THERAPIST | NA | NA | 16.2 | 18.5 | 9.9 | 7.1 |
| RESPIRATORY THERAPIST | 10.1 | 9.4 | 17.0 | 10.7 | 4.8 | 3.2 |
| MEDICAL TECHNOLOGIST | 7.2 | 8.6 | 6.3 | 8.3 | 3.1 | 3.0 |

Source: Ohio Hospital Association; Maryland Hospital Association; Missouri Hospital Association

As can be seen in the preceding table, while vacancy rates appear to be moderating overall, with some exceptions, there does not seem to be a clear pattern across all professions and states. And, looking at changes within just a two year period does not present a comprehensible picture over a longer span of years, particularly when retirements, workforce attrition, and other factors may have a large impact and change the situation.

When one looks at the variance in vacancies within a state, the importance of knowing the local workforce condition becomes more apparent. National workforce data may be of limited help. Even statewide data may present an inaccurate picture of what is happening in a specific locale as the following table illustrates.

MISSOURI 2005 FTE VACANCY RATE PERCENTAGE BY WORKFORCE INVESTMENT AREA

| | STATEWIDE | WIA-X | WIA-Y |
|------------------------|-----------|-------|-------|
| REGISTERED NURSE | 7.5 | 16.5 | 4.5 |
| OCCUPATIONAL THERAPIST | 6.8 | 29.1 | 1.0 |
| PHYSICAL THERAPIST | 7.1 | 20.6 | 0 |
| MEDICAL TECHNOLOGIST | 3.0 | 9.0 | 0 |
| RADIOGRAPHER | 3.7 | 7.6 | 0 |

Source: Missouri Hospital Association Annual Workforce Survey 2005 (<http://web.mhanet.com>) NOTE: There are 10 Workforce Investment Areas (WIA) in Missouri. In the above table, WIA-X represents the WIA with the greatest percentage vacancy and WIA-Y represents the WIA with the smallest vacancy percentage. The actual WIA regions are: Northwest; Northeast; Kansas City; West Central; Central; St. Louis; Southwest; Ozark; South Central; and, Southeast.

A number of factors can create personnel imbalances from one area of the state to another. Population density, location and number of health facilities, location of technical and community colleges, location of four-year institutions, the program mix and number of graduates of the educational institutions all contribute to variance from one geographic area to another. Perhaps with the exception of flagship institutions in the state, students tend to enroll in programs near their homes and seek jobs in the same area following graduation. As a general rule, the higher the degree level, the greater the mobility of the graduates and their willingness to move for employment. That is why community colleges fill primarily local needs and regional universities tend to fill sub-state regional needs. Due in part to the higher cost of health professions programs, it is more difficult for many institutions to conduct health programs, even when there is a demonstrated need for them.

In areas of a state with lower population densities, it is often difficult to justify or conduct a program for a variety of reasons, including access to appropriate clinical facilities and the ability to sustain over the years an adequate number of students to make the program cost effective. Once created, a program may saturate the local or regional employment market within a few years. For example, the Idaho Hospital Association (<http://www.teamiha.org>) in its position survey in which 38 member hospitals responded, showed a statewide vacancy rate of 4% for radiology technologists, but that represented only 12 positions. Likewise, the physical therapist vacancy rate of 7% represented 21 vacancies statewide, with one region showing a 5% vacancy rate with only 3 positions vacant. Mounting a program to address such a magnitude would be impractical. On the other hand, Idaho's hospital vacancy rate of 8% for registered nurses represents 337 positions.

Whether in a highly populated area or one that is sparsely populated, having accurate local data is essential for effective workforce planning. National or even statewide data may not reflect local needs.

Allied health as economic development: The September 25, 2006 issue of *Business Week* said it forcefully. With its article "What's Really Propping Up the Economy" and the article's sub-title, "Since 2001, the health-care industry has added 1.7 million jobs. The rest of the private sector? None.", attention was dramatically drawn to an important economic fact in the U.S.—health care is big business and is a growth industry. The article goes on to say the figures include related businesses such as pharmaceuticals and health insurance. The fact is that in many areas of the U.S., health care is the economic engine driving growth and successful local economies.

In 2006, Oklahoma's Governor's Council for Workforce and Economic Development announced the results of its health care industry study. Prominent was a strong concern about an expected shortage of health professionals—"If current trends continue, by 2012 Oklahoma is expected to have a shortage of more than 3,000 nurses, 600 lab technicians, 400 physical therapists, 300 surgical technologists, and nearly 200 occupational therapists...As one of Oklahoma's most important industries, health care continues to be a key element in the state's ability to recruit and retain new and expanding businesses...In 2004, health care was the second largest employing industry in Oklahoma, comprising 14% of the state's total employment."

Similar stories emerge from other states. North Carolina has proven to be a trailblazer in addressing the relationship of health care, and in particular, the allied health professions, to the economy of the state. Through numerous health workforce studies, developing and maintaining the North Carolina Health Professions Data System, an active and highly regarded AHEC, and partnerships between such entities as the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and the Council for Allied Health in North Carolina, the state has become a model for other states in addressing health workforce issues.

Through a variety of research activities, it has been shown that between 1990 and 2005, North Carolina lost 255,971 manufacturing jobs, but gained 230,476 jobs in health care and social assistance. Further, between 1999 and 2003, over 42% of total job growth in the health care sector was due to growth of allied health jobs. The state's partners in monitoring and addressing the condition of its health workforce have created an upcoming conference on June 15, 2007 in Chapel Hill on "The Impact of Health Care and the Allied Health Workforce on North Carolina's Economy". There is no registration fee and information regarding the conference can be found at <http://www.alliedhealthcouncilNC.org>.

The impact of the allied health workforce is being shown to have a significant impact on each state's economy. A key to demonstrating that impact and to determining how best to meet future needs is unmistakably tied to having good local and regional workforce data.

AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Wages Of Health Professionals

A new report from the Bureau of Labor Statistics (BLS) contains mean, median, and annual wages for various occupations, including many kinds of health professionals. National employment and wage data from the *Occupational Employment Statistics Survey* may be accessed on the Web at <http://stats.bls.gov/news.release/ocwage.t01.htm>.

New Web Resource for Accessing Information On Genetic Diseases

The National Library of Medicine's (NLM) National Center for Biotechnology Information has collaborated with the Genetic Alliance to launch a new Web site feature designed to help patients, care givers, health professionals, and others easily locate and navigate the vast array of information on genetic disorders that is available from the NLM. The "portal" into NLM resources brings together on one Web page links to a wide range of information for patients and caregivers—from basic descriptions of a disease and its symptoms to the most current scientific research. It is designed to serve the needs of a broad spectrum of users, ranging from those who are just beginning to learn about a disorder to those who understand complex scientific information, including those who want to track emerging information over time. The site may be accessed on the Web at <http://www.geneticalliance.org/>

The Future Of Disability In America

To understand disability in the United States better, the Centers for Disease Control, the Department of Education, and the National Institutes of Health (NIH) asked the Institute of Medicine (IOM) to assess the current situation and provide recommendations for improvement, which culminated in the report *The Future of Disability in America*. The committee reviewed the developments since two previous IOM reports on disability, analyzed a number of shortcomings in the nation's disability policies and programs, and raised serious questions about how individuals and society will cope with the challenges of disability. The report concludes that immediate action is essential for the nation to avoid harm and to help individuals with disabilities lead independent and productive lives. Additional information may be accessed on the Web at http://www.nap.edu/catalog.php?record_id=11898.

Behavioral Risk Factor Surveillance System Prevalence Data

The Centers for Disease Control and Prevention's (CDC) Behavioral Surveillance Branch in the Division of Adult and Community Health, National Center for Chronic Disease Prevention and Health Promotion, Coordinating Center for Health Promotion announced the release of the *2006 Behavioral Risk Factor Surveillance System (BRFSS)* prevalence data this week. The BRFSS is a state-based surveillance system active in all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands and Guam. Information on health risk behaviors, clinical preventive health practices and health care access, primarily related to chronic disease and injury, is obtained from a representative sample of non-institutionalized adults, 18 years and older, in each state. The BRFSS provides flexible, timely and ongoing data collection that allows for state-to-state and state-to-nation comparisons. State-specific data, including racial-and-ethnic-specific data from the BRFSS, provide a sound basis for developing and evaluating public health programs. The BRFSS is the largest telephone-based surveillance system in the world, with more than 355,000 interviews in 2006. The 2006 BRFSS state-by-state prevalence data can be accessed on the Web at <http://www.cdc.gov/brfss>.

INTEGRATED MEDICINE CONSULT SERVICE ESTABLISHED

The National Center for Complementary and Alternative Medicine (NCCAM) has established an Integrative Medicine Consult Service at the National Institutes of Health (NIH) Clinical Center. This service will provide physicians, nurses, and other members of the Clinical Center health care team the ability to discuss complementary and alternative medicine (CAM) therapies with knowledgeable medical staff from the consult service and learn how various CAM practices might complement or interact with a patient's care as a research participant at the Clinical Center. CAM is not a new concept at the NIH Clinical Center.

The Center's Pain and Palliative Care Service and the Rehabilitation Medicine Department offer acupuncture, Reiki, hypnosis, guided imagery, massage therapy, acupuncture, tai chi, and qi gong training. The Pharmacy Department consults on herbals and herb/drug interactions and has conducted research in these areas. The Integrative Medicine Consult Service will coordinate the resources of these existing services to meet the needs of the Center staff and its patients. In addition to offering clinical consultation regarding CAM therapies, the service will establish a research program embedded in NIH's clinical and translational research structure and provide CAM education for NIH staff, patients, and their families.

NEWS FROM THE COLLEGES

Barry S. Eckert, a seasoned educator with more than three decades of experience in allied health and medical education, will be the new dean of the School of Health Professions at Long Island University's Brooklyn Campus, University officials announced on Thursday, May 24, 2007. He will assume the title on September 1. Eckert goes to the Brooklyn Campus from Savannah, Ga., where he has been dean of the College of Health Professions at Armstrong Atlantic State University since 2001.

The School of Health Professions has more than 600 students enrolled in its divisions of Occupational Therapy, Physical Therapy, Physician Assistant Studies, Respiratory Care, and Sports Sciences. In addition to bachelor's and master's degrees, it offers an entry-level post-baccalaureate Doctor of Physical Therapy degree. The School was founded in 1984 as part of the Brooklyn Campus, which now educates more than 11,000 students.

ANNUAL CONFERENCE PRELIMINARY PROGRAM

The *Preliminary Program* for the 2007 ASAHP Annual Conference is being readied for distribution in June. It will contain an outline of the program, information on registration fees, and instructions on how to register.

INSTITUTIONAL PROFILE SURVEY

Data gathering for the Association's annual *Institutional Profile Survey* will begin in September. Once again, deans and directors are reminded of the importance of beginning to make preparations to participate in the next iteration of this study by identifying a key person who will collect and submit data. Only those members who participate in this endeavor will have access to the final results.

The study is a valuable source of information about faculty salaries as well as student applications and enrollments in 20 different kinds of academic programs. The results are made available each January in electronic format. A printed report is distributed each March. The latter item displays trends data from the 1999-2000 to 2006-2007 academic years. Obviously, the more member institutions that participate in the survey, the more rich are the findings. The high water mark was reached in 2005 when data were obtained from 95 schools. The aim in 2007 is to surpass that figure by having all member institutions be involved in the study.
