ROUTE TO: ____

TRENDS

Association of Schools of Allied Health Professions

HIGHLIGHTS

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VANGUARD OF ALLIED HEALTH EDUCATION

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THE AUDACITY OF NOPE

The ostensible purpose of the health reform summit that was hosted by President Barack Obama on February 25 in Washington, DC was to see if some level of agreement could be reached between Democrats and Republicans. An unstated reason was for him to galvanize his base among Democrats as a means of ensuring that they would provide the necessary votes to be able to move legislation to his desk for a signature regardless of the Summit's outcome.

The seven-hour discussion at the Summit was riveting in many ways, including anecdotes from some legislators regarding why it is important to enact health reform legislation. Candid views were exchanged that demonstrated the large gulfs that exist between Democrats and Republicans. Generally, these differences of opinion involve disagreements over how much Democrat proposals will cost, whether the federal government or market forces should hold sway over the provision of health care, and whether health reform initiatives should be broad and comprehensive or more limited and incremental in scope.

Even before the Summit took place, it was evident that Democrats planned to move full steam ahead with bills that already had been passed in both chambers of Congress. What they have in mind is for the House to accept the Senate bill, but then create a second piece of legislation that would serve to correct Senate elements that are disagreeable to some House members that pertain to such items as: abortion, taxing high-priced health plans, and the extent of subsidies that would be furnished to certain groups to offset the cost of purchasing health insurance coverage.

The victory of Scott Brown from Massachusetts in a Senate election deprived Democrats of the 60 votes needed to move their legislation forward by restricting the ability of Republicans to filibuster and impede passage. Instead, in the Senate Democrats may seek to pass a corrections bill by using a mechanism called reconciliation, which would require only 51 votes. Reconciliation was established in 1974 as a way to change existing laws to bring federal spending and revenue in line with what Congress prescribes in its annual budget resolution. The tool has been used on 17 occasions since then for a wide variety of situations involving Medicare, Medicaid, food stamps, and other kinds of programs involving taxes and expenditures. It has never been used for something as large as health reform, which encompasses 17.2 percent of the economy.

The House bill passed on a vote of 220 to 215. Since then, three members who voted yes have announced plans not to run for reelection. Other proponents in that chamber need to believe that the Senate will pass an agreed-upon corrections bill. Many House members are going to have to prove that they possess that degree of trust in obtaining a satisfactory product.

PRESIDENTS'S MESSAGE

By Gregory H. Frazer, ASAHP President

Greetings Colleagues! I'm sure you join me in awaiting the spring thaw. We are in the midst of the snowiest winter ever in Pittsburgh, having more snow this month than we have in an average winter season!

I'm sure your programs are much like ours in that the number and types of clinical sites vary from semester to semester. Our directors of clinical education are in constant pursuit of quality clinical opportunities that broaden the skill sets of our entry-level graduates.

Such a pursuit recently led me to visit the country of Liberia to explore possible clinical education sites. International clinical education is not a new concept as we have recently placed students in Vietnam, South Africa, and Haiti. This mission was initiated through contact with one of our university alumni, who suggested ample opportunities awaited our students.

I don't know about you, but Liberia was never on my bucket list. I knew it was in western Africa, had a decade long civil war, was founded by slaves, and that it was located close to the equator. As a result of my trip, I now know that the civil war started in 1989, ended in 2006, resulting in 200,000 deaths; there are 18,000 UN troops currently stationed in the country; that the daily year-round temperatures are between the 90s or 100s with humidity; the war destroyed the national electrical grid resulting in generators being used for power as well as the road network; only one functioning x-ray machine and autoclave exist among the five largest hospitals in the country; there is no running water or flush toilets in homes; there is 80% unemployment, the third highest adolescent fertility rate in the world; the third highest infant mortality rate in the world; ninth highest birth rate in the world; only one-quarter of the 3.4 million citizens have access to sanitation; 50% of the population is undernourished; and a life expectancy of 41 years. So much for the travel brochure. You have probably guessed by now that the challenging statistics are endless and yes, opportunity may abound but the risk to our students (including lassa fever) far outweighs the benefits and opportunities.

Was there any benefit to the trip? I often think of the challenges we face as administrators in this time of economic stress, faculty and resource shortages, healthcare reform, and programmatic competition, just to name a few. In fact, the trip afforded me the occasion to meet an individual named Steve Trexler, a Physician Assistant from western Maryland who gave up a 30-year clinical career as a cardiopulmonary and transplant physician assistant at Johns Hopkins Hospitals to begin a rural and community health clinical practice and to start the second physician assistant education program in Gbarnga, a city 125 miles northeast of Monrovia in the interior of Liberia, and home to the rebel insurgency.

Steve has successfully created an ARC-PA modeled curriculum approved by the Ministry of Education (which will now compete with the government-sponsored program), gotten a group to construct a building, is in the process of identifying power and water sources, contracting a carpenter to build seats, desks, and tables, creating a medical library, finding financial support for students to pay the $20/credit tuition, finding affordable housing for the students, and is in the process of identifying clinical education sites. So, as we cogitate copiously over our branding efforts, governmental relations challenges, assess how healthcare reform will impact our programs and students, attempt to measure student learning, among other issues, take pause that there are noble examples of success which should fortify our resolve to have an Association for which we are proud and one that supports the aspirations of our faculty, students, and programs! Happy spring!

HEALTH RELATED LEGISLATION

Health reform initiatives dominates the news, but there are related pieces of legislation that have the potential to exert some impact on health care in general and on the health workforce in particular. One example is a jobs bill. Monthly data continue to show that the U.S. economy is far from being a thriving enterprise. The unemployment rate still hovers around 10 percent, but it only reflects those individuals who still are seeking employment. When some workers who were laid off as the economy began its downward tumble found new jobs, oftentimes the new positions yielded much lower salaries and reduced benefits. Data on new home construction began to be collected in 1963. To provide another example, the number of starts recently was reported as reflecting the largest dip ever since that year. One result is that fewer jobs in the construction industry are needed.

Many unemployed individuals, along with those who found new jobs that pay less and offer fewer or no benefits may be unable to purchase health insurance coverage. Left behind are many premium holders who are older and sicker. They also are the ones who will feel the bunt of hefty premium hikes being announced by insurance carriers around the United States.

The Senate recently enjoyed bipartisan support in passage of a jobs bill. Spending at a level of $15 billion was approved. The House already had passed a bill with a price tag of $154 billion. Originally, the Senate was trying to pass an $85 billion bill. Going from $154 billion to $15 billion is quite a drop, but it reflects the wishes of Republicans who are loathe to add more federal costs and increase the national debt. Perhaps there is a lesson in this outcome, which could affect the amounts agreed upon in any health reform legislation that becomes law.

Similar to many walks of American life, a college level education is an entry level requirement for many jobs. The cost of higher education continues to exceed the overall inflation rate every year. One effort underway by the Obama Administration is to nationalize the lending industry that is part of the student loan program. Proponents believe that doing so will make it possible to increase the amount of money available under Pell Grants and related forms of student financial assistance. Opponents claim that the federal government will be less effective in servicing loans and in providing guidance and counseling to students. In addition, viewed through the prism of federal government efforts to exert control over the auto industry, banks, and financial companies, many voters may be inclined to resist further encroachment by the government in the private sector. Another consideration is that assuming total control of student lending could lead to a loss of jobs in the private sector. House and Senate members whose districts and states contain such companies may be reluctant to support any plan that will result in job losses.

2010-2011 ASSOCIATION CALENDAR OF EVENTS

March 11-12, 2010—Spring Meeting—St. Pete Beach, FL

October 20-22, 2010—Annual Conference—Charlotte, NC

March 15-16, 2011—Leadership Development Program—New Orleans, LA

March 17-18, 2011 — Spring Meeting — New Orleans, LA

October 19-21, 2011—Annual Conference—Scottsdale, AZ

COMPARATIVE EFFECTIVENESS RESEARCH AND HEALTH QUALITY

Comparative effectiveness research (CER) — studies that compare health care treatment options to inform decision-making -- is alternately described as the best or worst idea in the ongoing dialogue about how to fix American health care. A new *Robert Wood Johnson Foundation* policy paper that was developed in conjunction with the Urban Institute examines the implications of CER on U.S. health care. While health reform proposals being considered by Congress provide for some level of CER, studies show that much of the CER already being undertaken in the United States is not well coordinated, making it difficult to assess its true utility.

Efforts should be made to:

- Involve patients, clinicians, payers, and other decision-makers in CER study development and implementation.
- Improve the research infrastructure to enhance the validity and efficiency of CER studies.
- Develop a range of research methods applicable to comparative effectiveness (CE).

Fears about CE relate primarily to the potential misuse of information developed on comparative effectiveness. One example would be that CE will result in rationing of expensive, but effective treatment. Another one is that CE will promote government take-over of personal health care decisions. Additional concerns include:

- CE could promote one-size-fits-all medicine that does not account for the clinical needs of individuals or sub-groups of patients with special needs.
- CE could foster decisions that undervalue the patient's perspective, values, and preferences.
- CE will impede the speed of technological developments in health care, limiting the prospects for future improvements in treatment as expected investments are curtailed.

Although current health reform bills in Congress represent a step in the right direction, considerably more attention needs to be devoted to ascertaining why evidence so often has a limited and slow impact on practice. Implementation strategies must be disseminated more effectively. A challenge is to use cost as a criterion in selecting topics for CE, ensuring that CE focuses on areas with the greatest potential to increase the efficiency of health care delivery.

Health care in the United States represents more than $2 trillion in expenditures. Historically, less than 0.1 percent is allocated for comparative effectiveness initiatives. According to a Report Brief from the Institute of Medicine in 2009, it is estimated that one-half of the treatments and services that comprise standard medical care have been proven to be effective. Even when effectiveness is demonstrated, the degree to which it is more effective than alternative treatments and the circumstances in which it constitutes a more effective treatment often is unknown. Finally, there is the issue of adoption. In some cases it has been shown that it can take as long as 17 years before a clinically effective innovation is adopted.

The Robert Wood Johnson—Urban Institute policy paper can be accessed on the Web at http://www.rwjf.org/files/research/20100218qscomparativeeffectiveness.pdf.

PERSPECTIVES ON GEOGRAPHIC VARIATION IN HEALTH CARE SPENDING

A paper from the *National Center for Policy Analysis* indicates that while health care reform is definitely at the top of the domestic policy agenda, it is critical to flesh out a leading rationale, i.e., health care spending varies dramatically from region to region without producing commensurate variation in health outcomes. Lessons to be learned from geographic variation must take into consideration spending measures other than Medicare. Labeling states as high or low spending depends on the basis for the label used. The paper considers the degree to which demographics, income, health conditions and health market controls help explain the regional variation in spending as well as its persistence.

One of the perceived indicators of the health care system's inefficiency is the existence of the dramatic variation in spending in different areas of the country coupled with the observation that health outcomes in higher spending areas are not necessarily better than outcomes in the lower cost areas. Thus, adoption of the health care practice styles that exist in the low cost regions of the country has been mentioned as one way to reduce health care spending and increase efficiency.

Geographic variation is often identified by the variation in Medicare spending and this variation is implicitly assumed to hold in all others components of health care; however, there are numerous ways to think about geographic variation in health care spending and each would identify different high or low cost areas. For example, some geographic variation can be explained by differences in the demographic characteristics of the population and by health care market characteristics.

Thus, other factors are clearly at play that have produced persistently high or low spending in some areas or the country. In addition to demographic, income, health risks and market conditions, the percent of the population that is uninsured was also considered as one of the explanatory variables. As expected, a higher uninsured rate is associated with lower state health care spending in the non-Medicare/Medicaid population. In contrast, a higher percent of the population with no insurance resulted in higher Medicare spending per enrollee— indicating cost shifting to Medicare. The paper can be accessed on the Web at
http://www.ncpa.org/pdfs/Perspectives-on-the-Geographic-Variation-in-Health-Care-Spending.pdf.

ECONOMIC BURDEN OF HEALTH INEQUALITIES

A study commissioned by the *Joint Center for Political and Economic Studies* and carried out by researchers from Johns Hopkins University and the University of Maryland provides important insight into how much of a financial burden racial disparities are exerting on the U.S. health care system and society at large. Researchers examined the direct costs associated with the provision of care to a sicker and more disadvantaged population as well as the indirect costs of health inequities such as lost productivity, lost wages, absenteeism, family leave, and premature death.

More than 30 percent of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities – more than $230 billion over a three year period. When adding the indirect costs of these inequities over the same period, the tab comes to $1.24 trillion. Racial and ethnic disparities in health and health care impose costs on many parts of society, including individuals, families, communities, health care organizations, employers, health plans, and government agencies, including Medicare and Medicaid.

As legislators look for ways to make health reform pay for itself, it appears that eliminating health inequities can provide an important source of savings. In addition, given the Census Bureau's estimate that by 2042 half of the population living in the United States will be individuals of color, it is imperative that there be preparation to address the health needs of an increasingly diverse population.

The report can be accessed on the Web at http://www.jointcenter.org/publications_recent_publications/health/the_economic_burden_of_health_inequalities_in_the_united_states.

TRAINING NEW DENTAL PROVIDERS TO EASE DENTAL CARE CRISIS

A growing interest exists to establish new, mid-level dental providers in the U.S. The genesis of this interest is concern about access to care for underserved populations whose higher oral disease rates and unmet oral care needs are well documented. In May 2009, the Minnesota State Legislature established the Dental Therapist, the first mid-level dental provider sanctioned to provide care to U.S. non-Native populations in settings that serve low-income, uninsured, and underserved patients or are located in dental health professional shortage areas

Searching for ways to ensure dental care for millions living in dentist-shortage areas, the *W.K. Kellogg Foundation* released a wide-ranging assessment of international and U.S. experiences training and deploying new types of dental health care providers who could be used to help fill gaps in care. In particular, the report suggests that dental therapists, who perform preventive and basic dental services, could provide sorely needed care to millions of underserved Americans, working in collaboration with dentists while expanding their reach. Similar to a nurse practitioner or physician assistant in the medical field, dental therapists are envisioned as members of the dental team that is led by the dentist or dental specialist. Internationally, dental therapists have been used successfully for decades to address inadequate access to dental care.

The report can be accessed on the Web at http://www.wkkf.org/knowledge-center/Resources-Page.aspx.

THE CONNECTION BETWEEN LEARNING AND RESOURCES

American higher education is being challenged as never before by the imperative to increase postsecondary access and degree attainment despite declines in funding. The challenge is made all the more daunting because of rapid changes in student demographics. Meeting these challenges without harming quality will require unprecedented attention to the intersection of resource use and performance. Almost every institution is currently struggling to find ways to restructure its costs, a painful exercise that requires hard thinking about priorities and spending.

A paper from the *National Institute for Learning Outcomes Assessment* presents a conceptual approach for analyzing the relation of spending to student success, followed by an examination of what the existing research says about the topic. Since there is so little work directly on the topic of learning and resource use, this paper searches other areas of work for threads that might be sturdy enough to be woven into a fabric of knowledge about learning and resources. The document concludes by recapping the research themes and by suggesting directions for future work. It can be accessed on the Web at http://learningoutcomesassessment.org/documents/Wellman.pdf.

HEALTH INFORMATION TECHNOLOGY USE IN THE U.S.

The dynamic involvement of consumers in managing their own health care includes activities such as the use of computers (hardware and software) to access, retrieve, store, or share health care information. Activities may include using the Internet to look up health information, using e-mail or text messaging to communicate with health care providers or pharmacies, and having an electronic health record. As the percentage of adults in the U.S. who use the Internet continues to grow, the Internet may become increasingly important as a source of health information for consumers. A new report from the *National Center for Health Statistics (NCHS)* provides information about "Health Information Technology Use Among Men and Women Aged 18-64: Early Release of Estimates From the National Health Interview Survey, January-June 2009." The report can be accessed on the Web at http://www.cdc.gov/nchs/data/hestat/healthinfo2009/healthinfo2009.htm.

AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Health Spending Projections Through 2019

A new article in the Web Exclusives section of the journal *Health Affairs* indicates that the economic recession and rising unemployment-plus changing demographics and baby boomers aging into Medicare-are among the factors expected to influence health spending during 2009-2019. In 2009 the health share of gross domestic product (GDP) is expected to have increased 1.1 percentage points to 17.3 percent-the largest single-year increase since 1960. Average public spending growth rates for hospital, physician and clinical services, and prescription drugs are expected to exceed private spending growth in the first four years of the projections. As a result, public spending is projected to account for more than half of all U.S. health care spending by 2012. The article can be accessed on the Web at http://content.healthaffairs.org/cgi/content/full/hlthaff.2009.1074v1.

Long-Term Care Financing Lessons From Abroad

Broad health care reform legislation being considered by Congress would effect a major change in the way the United States finances long-term care. A new paper reviews the experiences of France, Germany, Japan, the Netherlands, and the United Kingdom and highlights some lessons the United States can learn from each. The paper can be accessed on the Web at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Feb/1368_Gleckman_longterm_care_financing_reform_lessons_US_abroad.pdf.

Cumulative Effects Of Job Characteristics On Health

There exists a cumulative negative effect of performing a physically demanding or environmentally hazardous job on worker health, but the effects vary substantially across age, race, and education groups. Individuals who work in jobs with the "worst" conditions experience declines in their health. Job characteristics are more detrimental to the health of females and older workers than to men or younger workers and the adverse health effects increase with the length of exposure to job conditions, according to a new Working paper from the *National Bureau of Economic Research*. Access to the paper can be obtained on the Web at http://www.nber.org/papers/w15121.

Top 10 Health Industry Issues In 2010

Each year *PricewaterhouseCoopers' Health Research Institute* publishes a report outlining key issues facing health industries for the coming year. In 2010, as the United States emerges from recession, health industries have an opportunity to move forward if organizations can effectively leverage relationships, understand the impact of pending reform and potential regulatory changes, and respond to changing consumer demands. The report can be accessed on the Web at http://pwchealth.com/cgi-local/hregister.cgi?link=reg/top-ten-health-industry-issues-in-2010.pdf.

Harsh Public Judgment On How Colleges Are Operated

Six out of 10 Americans now say that colleges today operate more like a business, focused more on the bottom line than on the educational experience of students. Furthermore, the number of individuals who feel this way has increased by five percentage points in the last year alone and is up by eight percentage points since 2007. These results are highlights from surveys tracking public attitudes on higher education conducted by the *Public Agenda for the National Center for Public Policy and Higher Education*. The 2009 results are based on a survey of 1,031 Americans conducted in December 2009. Additional information can be obtained on the Web at http://www.publicagenda.org/pages/squeeze-play-2010.

2010 ASAHP ANNUAL CONFERENCE

Planning for the *2010 ASAHP Annual Conference* in Charlotte, NC on October 20-22 has begun. Members of the committee are as follows:

ASAHP President **Gregory Frazer** (Duquesne University), Chairperson
Diane Bridges (Rosalind Franklin University of Medicine and Science)
ASAHP Board Member **Barry Eckert** (Long Island University—Brooklyn)
Jennifer Horner (Ohio University)
Edward "Ted" Kelley (University of Medicine & Dentistry of New Jersey)
Lee McLean (University of North Carolina at Chapel Hill)
Yasmen Simonian (Weber State University)

The group has expressed considerable interest in having a focus in the conference on interdisciplinary and outcomes research. Members of the Association's Research Committee will be actively involved in developing one concurrent session during the conference on outcomes research being conducted in institutions belonging to ASAHP. Another concurrent session will feature deans who are developing a culture within their respective schools that fosters this kind of research.

A series of roundtable discussions will be conducted. One of them will be on the topic of research. In addition, members of the Accreditation Committee will assist in developing a panel discussion featuring representatives of various accreditation organizations. A *Call for Abstracts* will be issued. Submissions for the concurrent sessions and the poster session will revolve around the major areas of *Research, Education, and Practice*.

The calendar of events for the conference is:

March—May	Planning Committee conference calls
March 31	Information on Annual Conference posted online (including a *Call for Abstracts*)
May 14	Deadline for *Conference Call for Abstracts*
June 15	Deadline for Planning Committee to rate Abstract submissions
July 2	*Preliminary Program* posted online
July 15	Deadline for notifying individuals who submitted abstracts
August 2	Registration for Annual Conference available online
September 1	Deadline for Annual Conference Sponsorships/Ads/Exhibits

ASAHP BOARD OF DIRECTORS MEETING

The Association's Board of Directors will meet in St. Pete Beach, FL on March 10 immediately prior to the Spring Meeting. The agenda will include a review of the proposed budget for the new fiscal year that begins on July 1. Other reviews will include the activities of committees and task forces. Guest speakers will present a proposal that entails ASAHP's possible role in assisting member institutions in the areas of student enrollment and clinical placement of students.