

TRENDS *Association of Schools of Allied Health Professions*

HEALTH REFORM LEGISLATION ENACTED

HIGHLIGHTS

MARCH 2010

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High drama was the order of the day when a vote was taken in the House of Representatives on the evening of March 21 to pass the Senate's version of a major health reform bill. Unlike previous health legislation that led to the creation of the Medicare and Medicaid programs in 1965, not a single Republican in either chamber voted in favor of Democratic health reform.

What this outcome bodes for the future remains highly uncertain. Many Republicans assert that the upcoming election will prove that they are right and that next November they will regain control over the House and Senate. Once that occurs, they will vote to repeal the new law. The problem with that likelihood ever unfolding is that President Obama will repeal whatever they produce and it is highly improbable that they will have enough votes to override his veto. A fall back position is to vote him out of office in 2012, elect a Republican as President, and then have the law jettisoned.

A related initiative is for state attorneys general to sue the federal government over the mandate for individuals to purchase health insurance. The situation represents a classic battle over the issue of states' rights. Constitutional experts on both sides of the matter have weighed in with opinions, but more conventional wisdom suggests that the federal effort will take precedence according to how the commerce clause of the U.S. constitution is interpreted.

Democrats are of the persuasion that many voters will be pleased when they see certain provisions of the law take immediate effect. As time unfolds, they believe that current anger among many voters will subside as familiarity with the law increases. They also argue that once entitlements become available, there will be great resistance by beneficiaries to have anything eliminated such as prohibiting the denial of insurance coverage for preexisting conditions.

Arguments over the costs of health reform and the necessity for increasing taxes on a wide scale will continue for at least another decade. Given the current level of national debt and the rate at which it continues to increase, opponents of health reform express grave concern about the negative impact high tax levels will have on future generations.

Depending on where one sits in the debate, health reform produces feelings of gloom or doom. Health workforce provisions include items that will benefit allied health. Examples are creation of a recruitment/retention/loan forgiveness program, creation of a mid-career training program, and expanded eligibility of area health education center programs and geriatric training programs to include allied health. The next step will be to have sufficient levels of appropriations to pay for these activities.



VANGUARD OF
ALLIED HEALTH EDUCATION

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PRESIDENTS'S MESSAGE

By Gregory H. Frazer, ASAHP President



It's a challenging time of year for most of us. We are barraged by the annual performance review process, holding our collective breaths as state legislatures meet to decide budgets or lack thereof, boards of trustees are meeting at our private schools deciding how much to increase already high tuition and fee rates, and for those of us lucky enough to shoulder this curse, having to take a pittance provided by our institutions to be distributed among our faculty and staff as merit increases, in many instances among members who have not received salary increases for a number of years.

So why is this “news”? I know many of our members continue to experience difficult times at their institutions, having to repetitively implement cuts due to decreases in state support for their colleges/schools and review their programmatic portfolios for those susceptible to closure or reorganization. A couple of weeks ago, I received a call from my former colleagues of over a decade ago at the University of Central Florida where I served as their chair. They informed me that the University was “dismantling” the department, closing the cardiopulmonary sciences (respiratory therapy), radiographic science, and health information management programs. Health management would be joined to an “informatics” major. All that was left of “health professions” from my tenure was physical therapy and athletic training. The reason for the closure: the programs were simply not big enough (enrollment) compared to other programs offered in the College. Nothing was said about faculty productivity, extramural support, quality of students enrolled in the program, ability to gain employment post graduation, the community need for graduates, or national standing of the programs. They just weren't big enough.

I suspect that you, like me, consult our “bible”, *The Chronicle of Higher Education*, on a regular basis hoping for a glimpse of something positive to come. Well, this past week the news was anything but fortifying. The March 28th electronic edition contained an article by Glenn and Schmidt that stated the recession has provided the backdrop for wide reaching reviews of programs with the “aim to weed out the allegedly weak ones.” In the same edition, Jeffery Brainard talked about the risk of having a multitude of small academic programs. He suggested that at least one-quarter of all academic programs in US colleges and universities awarded fewer than seven baccalaureate degrees. Disciplines with the smallest programs tend to be in chemistry, physics, and mathematics (algebra and calculus required for many of our programs), three foundational areas for virtually all of our programs.

So what does this have to do with our members? We all know our operational realities: we have smaller, higher demand, expensive programs. It is harder to recruit faculty, their salaries tend to be higher than their liberal arts colleagues, and we depend in many instances on our basic science colleagues for the foundational preparation of students. In state systems where tuition and fees are capped, the ROI is much lower for our programs. So riddle me this Batman: how do our members thrive (or should I say survive) in such a challenging time? Maybe its time to convene an ASAHP task force to study potential economies of scale that might evolve between programs that may have small enrollments, faculty recruitment difficulties, and/or resource constraints. Our specialized accreditation standards require that students have access to faculty, adjuncts, resources and opportunities. But they do not disallow consortia or partnerships to provide these requirements. In an age of scrutiny, accountability, and productivity, can our members afford to reinforce the status quo without at least a discussion of the possibilities and options available?

HEALTH REFORM



Following a vote of 219-212 in the House of Representatives to pass a Senate health reform bill, the next required step was for the Senate to pass a bill containing various corrections under budget reconciliation rules. The Senate passed the reconciliation bill 56-43. Then, the House voted 220-207 to pass the Senate reconciliation piece, which put in place the final piece of legislation. The scene now shifts to federal agencies that will be charged with the gigantic task of implementing the law. Given the fact that certain portions such as the imposition of an individual mandate to purchase health insurance are highly controversial, courts also will be involved in determining what unfolds.

Within the next six months, for example, officials at the Department of Health and Human Services will have to prepare and implement regulations such as rules to require insurers to allow dependents to remain on parents' plans until age 26, prevent plans from placing annual or lifetime limits on patients' care, and prohibit insurers from rescinding coverage except in cases of fraud. As various agencies undertake implementation they will have to write proposed rules, solicit and collect public comments, respond to comments, and release final rules.

Examples of some provisions that will take effect in 2010 are:

- ◆ Provides eligible individuals access to coverage that does not impose any coverage exclusions for pre-existing health conditions. This provision ends when Exchanges are operational. Effective 90 days after enactment.
- ◆ Bars health insurance companies from imposing pre-existing condition exclusions on children's coverage. Effective six months after enactment and applying to all employer plans and new plans in the individual market.
- ◆ Provides a \$250 rebate check for all Part D enrollees who enter the "donut hole." Currently, the coverage gap falls between \$2,830 and \$6,440 in total drug spending.
- ◆ Prohibits abusive practices whereby health insurance companies rescind existing health insurance policies when a person is sick as a way of avoiding covering the costs of enrollees' health care needs. Effective six months after enactment and applying to all new and existing plans.
- ◆ Eliminating Lifetime Limits. Prohibits insurers from imposing lifetime limits on benefits. Effective six months after enactment and applying to all plans.
- ◆ Tightly regulates plans' use of annual limits to ensure access to needed care in all group plans and all new individual plans. Effective six month after enactment and applying to new plans in the individual market and all employer plans

2010-2011 ASSOCIATION CALENDAR OF EVENTS

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 17-18, 2011—Leadership Development Program—Scottsdale, AZ

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

BOARD ACTIONS IN MARCH 2010

The Association's Board of Directors met in St. Pete Beach, FL on March 10. The following actions were among those taken:

- ◆ Approved the Minutes of a conference call on January 20, 2010.
- ◆ Approved a motion that the Association increase the equity portion of the portfolio of investments from 30% to 45%.
- ◆ Approved a motion to accept the recommendation from the Finance Committee regarding the annual budget and investments.
- ◆ Approved a motion to reallocate \$50,000 to endow the Scholarship Initiative Account.
- ◆ Approved a motion to place \$8,000 in the 2010-2011 budget for scholarships by transferring from investment funds.
- ◆ Approved a motion to place \$1,500 in the Switzer Initiative Account and allocate \$500 for a history of ASAHP project.
- ◆ Approved a motion to accept the 2010-2011 budget as amended.

Board Members heard presentations from representatives of the firms Enrollment Rx and Salesforce.com. regarding products that focus on enrollment services to address recruitment and the monitoring of student clinical placements. The next step will be to determine if they are willing to mount exhibits at the ASAHP Annual Conference.

REGISTERED NURSE SATISFACTION AND CAREER PLANS

Many allied health professions often are compared to nursing from the standpoint of the aging of the workforce, personnel shortages, and faculty shortages. Health reform legislation that recently was enacted is expected to increase the number of patients seeking care. Unless the health workforce grows in size accordingly, existing personnel will have more pressures placed upon them.

Nearly one-third of registered nurses (RNs) surveyed last month say they will not be working in their current job a year from now and close to half say they plan to alter their career path in the next one to three years that would either take them out of the nursing field entirely or reduce their contribution to direct patient care by working fewer hours or choosing a less demanding role. These are among key findings from *AMN's 2010 Survey of Registered Nurses: Job Satisfaction and Career Plans*.

The survey, which collected data from 1,399 respondents, was conducted during a period of economic recession and in the course of an ongoing national debate over healthcare reform. The survey reflects how RNs may have altered their career plans due to the recession, how they might respond to an economic recovery, and highlights whether they believe healthcare reform will address the nurse shortage.

The report is available on the Web at

<http://www.amnhealthcare.com/services-products/whitepapers-surveys-casestudies.aspx#Surveys>.

THE BLS 2008-2018 HEALTH WORKFORCE PROJECTIONS AND THEIR IMPLICATIONS

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Every two years the Bureau of Labor Statistics in the U.S. Department of Labor releases workforce projections for all areas of the economy for a ten year period. The latest projections were released this past December and are for the period 2008 through 2018. They can be found in the November issue of Monthly Labor Review, which is a free publication accessible on the BLS web site at <http://www.bls.gov/opub/mlr/2009/11/home.htm>. Most of the health professions and occupations are listed under the matrix codes 29 and 31 which are found on pages 107 through 109 of the publication.

A good bit of attention is given to the BLS projections for several reasons. First, they come from the federal government, they result from an extensive and complex macroeconomic analysis, and they are viewed as objective data free of advocacy or desires of the individual professions. Second, for many health professions and occupations, particularly the smaller occupations, there are few other objective workforce data sources available.

Obviously, the BLS makes a number of assumptions and observations in developing their employment projections. One of these is the realization that we are currently in a recession. The projections are based on the assumption that the economy will return to its normal growth path by 2018 and that no other events or ‘shocks’ will occur that would precipitate an economic downturn, or recession. Examples of such shocks are the oil crisis of the early 1970s and 80s, the collapse of the dot-com bubble in the early 2000s, and the severe losses in the financial and real estate markets in the latest recession.

In comparing the BLS numbers for the health professions and occupations with other areas of the economy, several points of reference will be helpful. The U.S. workforce is projected to grow by 10.1 percent during the ten year period, or an annual average of about 1.0 percent for all industries. By contrast, the “healthcare practitioners and technical occupations” (which is category 29) is projected to grow by 21.4 percent and the “healthcare support occupations”, (category 31), is projected to grow by 28.8 percent. Both of these are over twice the growth in the workforce as a whole.

The good news is while jobs in many areas of the U.S. economy have been shrinking, there has still been growth in health care, especially in the hospital industry. However, the rate of growth in 2009 has been slower than in previous years. Overall, the health care sector has added 613,000 jobs since the beginning of the recession in December 2007.

The professions of medicine and nursing continue to be the subject of much health workforce discussion because they occupy such a large role in the health system. In 2008 there were over 2.5 million working registered nurses in the U.S., making it by far the largest single health profession. Over the 2008-2018 ten year period, over one million new and replacement registered nurses will be needed, making it the nation’s top profession in terms of projected job growth. A cause for concern, however, is a recent National League for Nursing report indicating that the growth in enrollments in entry-level registered nursing programs is leveling off (http://www.nln.org/newsreleases/annual_survey_2010.htm). It should also be pointed out that what happens in medicine is extremely important to most of the allied health professions. That is because most of the allied health professions are dependent on what actions physicians take and the advances that occur in medicine.

The table in this article indicates the employment in various health professions in 2008 and the anticipated growth by 2018, including the number of job openings due to growth and replacement of current workers due to retirements and those that leave employment due to other reasons. While substantial growth is expected in most of the health professions, the greatest growth is projected to occur in those fields at the lower training levels. This results from what has been an ongoing trend in cost containment efforts within the health system, and a bifurcation of the health workforce. The bifurcation has pushed the workforce in opposite directions—toward higher trained individuals due to increasing degree requirements in a number of professions and lower trained individuals due to employers seeking to hire the lowest trained and compensated individual who can competently perform the necessary tasks at hand.

Health Workforce Employment 2008-2018

Numbers Listed are in Thousands of Jobs

OCCUPATION	EMPLOYMENT		CHANGE		TOTAL JOB OPENINGS DUE TO GROWTH AND NET REPLACEMENTS, 2008-18
	NUMBER		NUMBER	PERCENT	
	2008	2018			
TOTAL, ALL OCCUPATIONS	150,932	166,206	15,274	10.1	50,929
HEALTHCARE PRACTITIONERS & TECHNICAL OCCUPATIONS	7,491	9,091	1,600	21.4	3,139
HEALTHCARE SUPPORT OCCUPATIONS	3,982	5,130	1,147	28.8	1,595
PHYSICIANS AND SURGEONS	661	806	144	21.8	261
REGISTERED NURSES	2,619	3,200	582	22.2	1,039
OCCUPATIONAL THERAPISTS	105	131	27	25.6	46
PHYSICAL THERAPISTS	186	242	56	30.3	79
PHYSICIAN ASSISTANTS	75	104	29	39.0	43
SPEECH-LANGUAGE PATHOLOGISTS	119	141	22	18.5	44
ATHLETIC TRAINERS	16	22	6	36.9	12
MEDICAL & CLINICAL LAB TECHNOLOGISTS	172	193	21	11.9	53
MEDICAL & CLINICAL LAB TECHNICIANS	156	181	25	16.1	55
DENTAL HYGIENISTS	174	237	63	36.1	98
RADIOLOGIC TECHNOLOGISTS AND TECHNICIANS	215	252	37	17.2	68
RESPIRATORY THERAPISTS	106	128	22	20.9	41
HOME HEALTH AIDES	922	1,383	461	50.0	553
MEDICAL ASSISTANTS	484	648	164	33.9	218

Source: table prepared by Stephen N. Collier using data for the Bureau of Labor Statistics: Occupational Employment Projections to 2018, Monthly Labor Review, November 2009.

While the BLS projections provide one estimation of the future needs in health care, caution should be exercised to not place too great an emphasis on the accuracy or precision of the projections. It is very difficult to project anything ten years into the future with a great deal of confidence in the projections. Even if the BLS projections are accurate in an overall sense, one needs to realize there can be considerable geographic variation in the local supply and demand for those working in health care due to a variety of reasons, including the presence or absence of educational programs in a local area. Also, the projections should not be viewed in a linear fashion with each year representing one-tenth of the total projection. While there may currently be fewer job openings available due to workers postponing retirement, the greatest growth in job openings may occur in the later years of the decade.

Individual professions may also take exception to the BLS projections for their profession. For example, educators and others have expressed a good bit of concern about the clinical lab workforce and the reduction in educational capacity over the last several decades. Even though advances in technology, primarily related to equipment, have affected lab professionals, there is still concern that we may not be producing enough graduates to meet the future demand, even though the BLS numbers don't necessarily reflect that.

A natural question, particularly for ASAHP members, is whether a sufficient number of graduates are being produced to meet the current and future health workforce needs. If one takes the data in the last column of the table—the total job openings due to growth and net replacements—and divides it by ten to get an annual average number, and then compares it to the number of graduates nationally as listed in the AMA's Health Professions Education Data Book, it can be seen that for many professions there is a significant shortfall in educational production. Because it takes a number of years to ramp up production of graduates either from the creation of new programs or the expansion of enrollments in existing programs, this is likely to create a serious policy issue for the future. The coming years may continue to be turbulent ones for both educators in the health professions as well as for employers.

AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Health, United States, 2009

Health, United States, 2009 is an annual report presenting national trends in health statistics. It includes an executive summary, highlights, and 150 detailed trend tables organized around four broad areas: health status and its determinants, health care utilization, health care resources, and health care expenditures. The report contains 36 charts and this year's chart book special feature is on medical technology.

The report can be accessed on the Web at <http://www.cdc.gov/nchs/data/hus/hus09.pdf>.

County Variations In Health Status: Patients' Residence Matters

A report detailing the first-ever county breakdown in each state finds wide disparities in health standings and notes factors contributing to those rankings. Residents of rural counties are especially challenged by high poverty and a lack of access to primary care, according to a set of rankings released by the Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. The report is the first-ever county-level analysis of the health status of individuals and factors affecting it.

The report can be accessed on the Web at <http://www.countyhealthrankings.org/latest-news/county-health-rankings-national-comparisons>.

State-By-State Look At How Health Dollars Are Spent

A March 2010 report from the Trust for America's Health (TFAH) and the Robert Wood Johnson Foundation (RWJF) found federal spending for public health has been flat for nearly five years, while states around the country cut nearly \$392 million for public health programs in the past year. These cuts leave communities around the country struggling to deliver basic disease prevention and emergency health preparedness services. States are expected to cut budgets even more in the coming year, which will further limit the ability of public health departments to carry out services. The report can be accessed on the Web at <http://healthyamericans.org/assets/files/TFAH2010Shortchanging05.pdf>.

Higher Education And The Common Core State Standards

The Common Core State Standards Initiative published a draft of proposed common standards in math and language arts that are designed to help states reach consensus on what it means to be college ready. The initiative is a joint effort by the National Governors Association (NGA) Center for Best Practices and the Council of Chief State School Officers (CCSSO). Governors and state commissioners of education from 48 states are committed to the state-led process to develop a common core of college- and career-ready standards in English language arts and mathematics for grades K–12. The standards can be reviewed on the Web at <http://www.corestandards.org/Standards/index.htm>.

Health Literacy Training For Health Professionals

As a means of helping public health professionals respond to limited health literacy, the Centers for Disease Control and Prevention (CDC) has launched a free, online training program: "Health Literacy for Public Health Professionals." Limited health literacy affects nine out of ten adults and has an impact on their capacity to fully manage their health. The training program can be accessed on the Web at <http://www.cdc.gov/healthmarketing/healthliteracy/training/>.

2010 ANNUAL CONFERENCE

Papers for concurrent sessions and the poster session are being solicited in the general areas of research, education, and practice for the *2010 ASAHP Annual Conference* that will be held on October 20-22 in Charlotte, NC. The deadline for responding is **May 14**. Information on how to do so is on the Association's homepage at www.asahp.org. The planning committee for the conference has selected the following topics for discussion by roundtable groups:

- ◆ Community health in the context of cultural diversity and health literacy
- ◆ Interprofessional education/dual degrees
- ◆ Electronic medical information
- ◆ Curricular innovations
- ◆ Global health initiatives
- ◆ Research
- ◆ Centralized application systems

THE PROMISE OF PREVENTION

An article by Goodarz et al in the March 23, 2010 issue of *PLoS Medicine* indicates that life expectancy (a measure of longevity and premature death) and overall health have increased steadily in the United States over recent years. Yet, some Americans live much longer and much healthier lives than others. Health disparities—differences in how often certain diseases occur and cause death in groups of people classified according to their ethnicity, geographical location, sex, or age—are extremely large and persistent in the U.S. On average, black men and women in the U.S. live 6.3 and 4.5 years less, respectively, than their white counterparts; the gap between life expectancy in the U.S. counties with the lowest and highest life expectancies is 18.4 years for men and 14.3 years for women.

Disparities in deaths (mortality) from chronic diseases such as cardiovascular diseases (for example, heart attacks and stroke), cancers, and diabetes are known to be the main determinants of these life expectancy disparities. In this study, the researchers estimate the effects of smoking, high blood pressure, high blood sugar, and adiposity on U.S. life expectancy and on disparities in life expectancy and disease-specific deaths among the “Eight Americas,” population groups defined by race and by the location and socioeconomic characteristics of their county of residence. Reduced exposure to preventable risk factors through the implementation of relevant policies and programs should reduce life expectancy and mortality disparities. The article can be accessed on the Web at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000248>.

THE INFLUENCE OF HEALTH CARE ON LIFE EXPECTANCY

Life expectancy in the U.S. lags below that in other industrialized countries. The U.S. also spends more on health care than other nations. The coincidence of these two facts has led some policy makers and health analysts to wonder if a highly inefficient U.S. health care system is to blame for poor health outcomes, a question examined by researchers Samuel Preston and Jessica Ho in a recent *National Bureau of Economic Research* publication (NBER Working Paper 15213). They note that one reason to be cautious in drawing a causal inference from the coincidence of high spending and poor health outcomes is that health outcomes do not depend solely on what transpires within the health care system. Personal health behaviors such as diet, exercise, smoking, and compliance with medical protocols play a critical role. The authors focus on two diseases - cancer and cardiovascular disease. It is useful to focus on treatment and outcomes for those with the disease, rather than disease incidence rates, since health behaviors are likely to play a bigger role in incidence. To the question "does a poor performance by the U.S. health care system account for the low international ranking of longevity in the U.S.?" the authors answer no. Information on how to obtain the paper can be accessed on the Web at <http://www.nber.org/papers/w15213>.