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Florida Public Health Review

Volume 10

Article 5

2013

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Why I Am *Optimistic* about My Post PhD-degree Life – A Commentary

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ABSTRACT

Public health is an area where we will always need professionally-prepared people. Whereas some soon-to-be graduates are concerned about their future job prospects, others express optimism, undeterred by the economic downturn of the past five years and the funding challenges that currently burden higher education. Staying focused and finding the right niche may be the key to a successful future.

Florida Public Health Review, 2013; 10, 12-13.

I am not worried about my post-degree professional life. I intend to pursue a health services research position in an academic setting. Recent legislation and the adoption of expanded quality standards by a key government health insurers support the relevance of my specialized career path. The Patient Protection and Affordable Care Act (PPACA) was enacted in 2010 with provisions that include covering most uninsured Americans, eliminating unnecessary spending and treatment in the health care system as a whole, and particular, for Medicare beneficiaries (Davis et al, 2011). The PPACA also allowed for the establishment of the patient-centered outcome research institute (Patient-Centered Outcomes Research Institute [PCORI], 2013). During the same time period, the Center for Medicare and Medicaid Services approved inflammatory bowel disease (IBD) specific quality metrics that were implemented in 2012 (Centers for Medicare and Medicaid Services, 2012). The enactment of these landmark policies should improve healthcare access for millions of Americans while also redirecting or eliminating billions of dollars in wasteful spending in the healthcare system and improving the quality of care received. These policies are of particular importance to my professional future. Specifically, I have been a clinical pharmacist for 20 years with formal training in epidemiology for over a decade. I have recently returned to academia for additional training in methodology to pursue a role as a health services researcher. In my previous clinical role I worked with patients that had long-standing IBD requiring on-going specialized nutrition support at home, I subsequently wrote institutional drug policy for a major health system to help manage IBD and other illnesses. Patients requiring parenteral or enteral nutrition therapies cannot absorb nutrients adequately—this health state is frequently due to repeat surgical interventions as a means to eliminate inflamed sections of bowel and control disease symptoms. For the vast majority of IBD patients surgical interventions are a negative health outcome as are hospitalizations and maintenance doses of steroids. National treatment guidelines affirm that IBD should be managed primarily in an ambulatory setting with steroid sparing pharmacotherapeutic regimens (Kombuth & Sachar, 2010; Lichtenstein et al, 2009). My prior clinical responsibilities made me aware of the need for drug therapy optimization in IBD patients as well as the sequelae associated with suboptimal treatment. These experiences led to my desire to contribute to the data available to inform drug therapy selection and policy development that would ensure consistent and appropriate management of these patients.

IBD is estimated to cost $6.3 billion annually in the United States (Kappelman et al, 2008). Biologic therapies, though expensive ($2000-$4000/month) have been shown to improve treatment outcomes in younger IBD patients with moderate to severe disease (Kappelman et al, 2008; Leombrunto et al, 2011; Lichtenstein et al, 2005; Park & Bass, 2011). Specifically, they have been shown to decrease the need for surgeries, hospitalizations and chronic corticosteroid utilization. IBD patients have normal or near normal life expectancies; there is a bimodal peak onset and older individuals are living longer, and therefore, IBD prevalence in older individuals is increasing. This trend is important because the clinical drug trials, cost-effectiveness analyses and efficacy studies conducted with biologics in IBD have not been

done in patients' ≥65 years old. Therefore, although IBD is an expensive disease state and older patients are more complicated to manage due to numerous comorbidities and polypharmacy, appropriate drug selection and associated treatment outcomes in older IBD patients represent a significant gap in our knowledge. Drug utilization trends and associated treatment outcomes in older IBD patients is the current focus of my research program.

Diseases that are difficult and expensive to manage that are increasing in prevalence and that are amenable to more cost-effective approaches to achieve improved patient-centered outcomes are prime targets for PCORI funding. PCORI (2013) has awarded $88.6 million to 51 projects over 3 years and even without congressional reauthorization, the institute is funded through 2019. Robust health services research, population health, pharmacoepidemiology and health outcomes research programs located within academic institutions and departments within institutes are committed to conducting the research required to achieve better health and healthcare outcomes in these types of expensive, difficult to manage populations. These academic departments and institutes need to hire individuals who have the ability to conduct this research and who have the credentials to compete for PCORI and other outcomes research funding.

Although total research dollars have been decreasing over the last several decades and funds and research positions have become increasingly competitive, I believe that the need to improve healthcare access, quality, and spending has not only necessitated the PPACA legislation, but also, the need for researchers with diverse backgrounds equipped to ask questions in unique ways. As a policy-oriented, clinically-trained pharmacist and health services outcomes researcher, I will be well situated to contribute to this essential body of research. Therefore, I believe that my post-degree professional life will be rewarding and beneficial to society.

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