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From the Editor

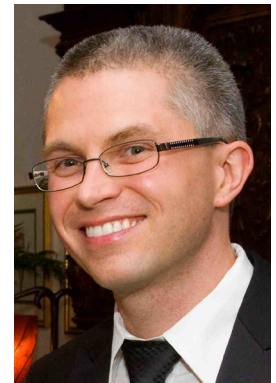
Interprofessionalism and the Health Insurance Exchange

As I write this, the US government has temporarily shut down in a highly-partisan debate over national health care. Although the U.S. has rejected the single-payer system of Canada and much of Western Europe, there is still contention over the nature of the Affordable Care Act. Like Social Security and Medicare before it, the sweeping changes that came out of the Great Depression and Vietnam Area, change doesn't come without significant growing pains.

Since the provisions of the Act are somewhat complex, some localities are providing navigators to help consumers to access health care when the law takes effect in January of 2014. This has been answered in a few populous places (like Florida and Texas) with state mandates to prevent use of these navigators. Urban county governments in some of the affected counties have chosen to ignore these mandates when local jurisdictions have ruled otherwise. Other states, however, have had less dissension.

For example, starting this month, the state of Oregon is rolling out its Health Insurance Exchange. This exchange, our state's response to the Affordable Care Act, is intended to extend insurance coverage to several groups of Oregonians that have traditionally been un- or underinsured. Similar efforts are taking place in other states across the country—and a federal exchange is available for individuals in states without a local option. By the time this editorial is published, thousands of the un- or underinsured will be signing up for health insurance exchanges, often assisted by librarians who have been trained for this purpose. (To raise awareness of the Oregon exchange, catchy Woodie Guthrie-style ads have appeared in the past months (like the one to the right). The choice of local

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musicians to write the music and lyrics for these ads was deliberate. Many musicians are self-employed and uninsured, and have significant enthusiasm for finally qualifying for health care under the Affordable Care Act.)



One of several ads for Cover Oregon (<http://youtu.be/Xv2UUcXC09g>)

As we enter what I called in the previous issue “the uncharted waters of the Affordable Healthcare Law,” which will potentially see greater numbers of individuals seeking healthcare (particularly from traditionally underinsured populations like small business

employees, the self-employed, and Native American tribal communities), and which will emphasize efficiency and best practices in the provision of that care, interprofessional practice becomes all the more important. For example, many of us are working towards achieving “meaningful use” with our electronic medical records. For optometry, this includes e-prescribing, which not only saves paper (and legibility transcription errors), but allows health care providers to access a potentially more accurate list of medications that are not limited to one provider or by patient memory.

In this issue of HIP, several manuscripts deal with communication and cooperation among various health care providers for the purpose of improving the quality of care. Two manuscripts are from countries outside the U.S., which may prove instructive for providers in this country as we seek new models of care. One (Australia) has national health care, and the other (Nicaragua) does not.

In the sole original theory and research contribution in this issue, Tranmer et. al. share a national survey of health care practitioners’ knowledge of oral hygiene and care for cancer patients. As the authors state, the complications can be profound, and are rarely investigated outside the dental profession. Their widely-distributed, but much less widely responded to, survey is evidence of this fact.

In one of two educational strategy articles, Jobst et al. discuss the use of a fibromyalgia case in interprofessional education, using survey results from professional students. Note that most of those who participated were pharmacy students, who stand at the nexus of meaningful use. While they are not a prescribing profession, patient benefits can be gained from other professions by working more closely with pharmacists.

In an educational strategy article from rural Australia, Gillan and her colleagues discuss how nursing, social work, medicine, and pharmacy each dealt with a simulation of palliative end-of-life care. Not all health care providers are routinely involved in hospice and geriatrics at the end of life, but it is vital for providers to consider their potential roles, especially when patients may not be able to effectively speak for themselves.

Next, an interview with Farinde discusses age-related changes in pharmaceutical selection, and includes audio

of the interview, which addresses interprofessionalism in a residential care facility.

Finally, Boggis et al. take us to Nicaragua as they explore cross-cultural issues in the provision of interprofessional care in hogares (nursing homes). The authors partnered with graduate students from dental hygiene, pharmacy, physician assistant, physical therapy, and occupational therapy to provide care in Nicaragua, where very few resources are available to the few caregivers at these underfunded facilities.

As we round the corner into the new world of the Affordable Care Act, we look forward to serving more patients and to bridging the gap between practitioners, one patient at a time.

In good health,

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