ILLUSSIONS IN THE HEALTH DOMAIN

As described in the March 2017 issue of the journal *Neurorehabilitation & Neural Repair*, mirror therapy (MT) is a rehabilitation strategy based on the repeated use of the mirror illusion (MI). Patients train by looking into a mirror placed along their midline and hiding their defective limb. The observed reflection of the unimpaired limb superimposes itself on the defective one, thus generating the visual illusion of a functional limb.

MT initially was devised as a strategy to alleviate phantom limb pain in amputees, before being applied as a neurorehabilitation approach for hemiparetic adults after a stroke. Currently, there is increasing evidence from randomized controlled trials regarding the effectiveness of MT for improving upper extremity motor function, activities of daily living, and pain, at least as an adjunct to normal rehabilitation for adults following a stroke.

Meanwhile, opinion polls suggest that many Americans are disenchanted and less inclined to believe that the federal government represents a positive force in their lives. Along lines of contemporary illusions, public policy salons sometimes are characterized as being nothing more than dens of blue smoke and mirrors. Despite the presence of citizenry views that express less than total optimism with governmental interventions, certain developments in the health domain are worthy of consideration as a means of possibly attenuating negative assessments.

The U.S. population is aging, and with old age there is an increase in both the incidence and prevalence of chronic conditions. Apart from individuals at younger ages who experience pain and related ailments stemming from accidents and a broad array of diseases, the aged by themselves are placing great demands on services provided by rehabilitation health professionals, such as physical therapists, occupational therapists, and speech-language pathologists.

On May 25-26, 2016, the National Institutes of Health organized a conference with the title “Rehabilitation Research at NIH: Moving the Field Forward.” The main objectives of the event were to (1) discuss the current NIH rehabilitation research portfolio, (2) highlight advances in rehabilitation research supported by NIH, and (3) provide an opportunity for scientists and the general public to comment on gaps in knowledge, opportunities for training, and infrastructure needs.

Rich discussions occurred on topics, such as moving rehabilitation interventions from a traditional “one-and-done” isolated model of care to one where such interventions are integrated into the mainstream of health care. Barriers to integrating function-directed care into the comprehensive management of progressive diseases, particularly those with a heavy treatment burden, were identified. Currently, 17 NIH institutes and centers fund rehabilitation research. Hence, the opportunity to bring representatives of these entities at one time to the same event opens up the possibility of achieving enormous gains in health care.
Many of our colleges and universities have closed out another academic year or are making arrangements to do so. Congratulations to all of our new allied health professionals and to all who have contributed to their success.

In addition to this time of the year celebrating commencements, the end of this month marks a federal holiday, Memorial Day. Memorial Day serves as a time when we commemorate the women and men who have died while in military service for the United States. In December 2000, the “National Moment of Remembrance” resolution was passed.

This resolution asks that at 3:00 PM local time (a time when many are enjoying their freedom) all Americans voluntarily pause from whatever they are doing for a moment of silence to reflect on the sacrifices that were made by our fellow Americans. As ASAHP members and allied health care professionals I ask that we remember our fellow colleagues and their family members and friends who have sacrificed their life for our country.

Allied health professionals have played very special roles in the various branches of the military. They serve as administrators, researchers and important preventative care and rehabilitation specialists. We are also familiar with the roles that our allied health professionals play in the VA hospitals and medical military centers caring for our veterans upon return.

We recognize the need to offer area of specialized care to our veterans. As such, one of the many topics offered at the upcoming 2017 annual ASAHP conference is “Best Practices in Veteran’s Health Care.” The 50th Anniversary Annual Conference will be held October 18-20, 2017 at the San Antonio, Marriott Riverwalk, San Antonio, TX. The ASAHP website (http://www.asahp.org/conferences) provides preliminary topics offered and registration information.

San Antonio is also the home of The Center for the Intrepid next to the Military Medical Center. The Intrepid focuses on the rehabilitation of burn victims and those individuals who have experienced limb amputation. Be sure to mark your calendars and plan to attend ASAHP at 50 – Reflections on the past, a window to the future of healthcare. Stay tuned for more information coming soon. The speaker line up has much to offer all!

In closing, I take this opportunity, on behalf of ASAHP, to pause and remember all of our fallen military men and women. Additionally I thank all veterans and the allied health care professionals providing care to our military and returning veterans.

Have a relaxing and joyful summer.

Linda
FEDERAL BUDGET VAGARIES

A common occurrence is for a President’s budget proposal for a new fiscal year to be pronounced as dead on arrival when it is submitted to Congress. What President Trump furnished on May 23 for FY 2018 was no exception. Last March, alarm bells were sounded in response to his budget blueprints, the so-called “skinny budget,” that called for a 19% reduction in National Institutes of Health (NIH) spending, among other healthcare spending cuts. His more detailed, final budget has even more extensive cuts across a wider array of programs, including the elimination of $839 billion from Medicaid, along with a $7.16 billion reduction for the NIH.

Not too surprisingly, Members of Congress had strong negative reactions to the budget proposal. Given the key role that they play in deciding how much to allocate for programs that involve spending, it is likely that major alterations will be made in the Administration's proposal. Each chamber is expected to produce its own budget resolution to exemplify how federal money should be apportioned.

Events thus far typify the old saying that what the right hand gives, the left hand takes away. Earlier this month, President Trump signed into law the bipartisan Consolidated Appropriations Act, also known as the omnibus spending bill for the remainder of fiscal year 2017, which ends on September 30. A highlight is that the legislation provides considerable funding to support the implementation of the 21st Century Cures Act to accelerate safe and effective treatments and cures for patients.

Several amounts are in marked contrast to what his Administration proposes for the upcoming fiscal year. The bill provides a $2 billion increase in funding for the NIH to support important research, including $352 million for NIH Innovation Projects authorized by the 21st Century Cures Act. The bill furnishes $6.2 billion in budget authority for the Health Resources and Services Administration, a nearly $74 million increase over FY 2016, although $50 million of the increase is in the form of a transfer of the Behavioral Health Workforce Education and Training program from the Substance Abuse and Mental Health Services Administration. Also included in the spending bill was a $39 million increase in discretionary funding for the Food and Drug Administration (FDA), at least $10.9 million of which is dedicated to medical product safety and precision medicine initiatives outlined in the 21st Century Cures Act. These appropriations, along with industry user fees, will play an essential role in accelerating the discovery, development, and delivery of new cures and treatments to Americans.

The American Health Care Act narrowly was passed by the House of Representatives this month to repeal and replace the Affordable Care Act. More information about this legislation is on page four of this issue of the newsletter.

2017 ASSOCIATION CALENDAR OF EVENTS

June 9, 2017—Scholarship of Excellence Applications Deadline

June 15, 2017—Deadline for Submitting Annual Conference Abstracts

July 10-11, 2017—Board of Directors Meeting

September 2017—ASAHP Election Results Announced

October 18-20, 2017—ASAHP Annual Conference in San Antonio, TX
AFFORDABLE CARE ACT DEVELOPMENTS

Despite several positive aspects of the Affordable Care Act that is in its eighth year of existence, it is clear even to its many supporters that some changes are necessary. For example, a report issued this month from the Urban Institute indicates that median monthly benchmark premiums directly correlate with the number of insurers participating in a given rating region. The more the number of insurers, the lower are both the amount of the premium and the rate of premium increase. Yet, on May 24 of this year, Blue Cross Blue Shield of Kansas City withdrew its ObamaCare plans for 2018 in Kansas and Missouri, citing unsustainable losses. The decision will leave 77 of Missouri’s 114 counties, including St. Louis, with a single insurer, and some 31,000 Missourians in another 25 counties with no coverage options. According to the Department of Health & Human Services (HHS), premiums have increased by 145% on average in Missouri over four years. Along similar lines, Aetna on May 11, 2017 announced plans to withdraw from all ACA markets in 2018.

Other states around the nation also have been affected by declining insurance company participation and increasing premium rates. Congressional Republicans have capitalized on these issues by demanding that the ACA be repealed and replaced. A House of Representatives version of the American Health Care Act (AHCA) that was passed this month in its chamber is being considered in the Senate where it is expected to undergo significant modifications. Meanwhile, opponents claim that the legislation is equivalent to a proposed cure that, if enacted, will be worse than the disease.

Main Components of H.R 1628, American Health Care Act
Legislation passed on May 4, 2017 on a vote of 217-213 in the House of Representatives consists of the following main components:

Taxes: (1) Delays the 40% so-called Cadillac tax on high-cost health plans until 2025, (2) Repeals the prohibition of using health savings account (HSA) funds for over-the-counter medications, (3) Repeals the 2.3% tax on medical devices, (4) Repeals the tax on branded prescription drugs, (5) Repeals the tax on health plans and (6) Repeals the 0.9% Medicare tax on earned income of $200,000/$250,000.

Health Insurance Market: Changes the amounts and distribution of financial assistance for individuals purchasing health coverage. Some enrollees may have lower financial assistance. The AHCA removes many conditions for using tax credits to purchase coverage. The result is expected to be lower premiums for younger beneficiaries and higher premiums for older beneficiaries.

Funding For High Cost Populations: The bill includes $138 billion over 10 years to address the problem of high health care costs for some patients. A Patient and State Stability Fund for states would subsidize premiums. If states did not apply for the funds, they would go towards reinsurance for health plans.

Medicaid: Both the ACA expansion part of the program where 31 states chose to expand coverage under the ACA and the part of the program in place before the ACA would change. States could choose to have funding in the form of a block grant and could not expand Medicaid after March 1, 2017, unless through a waiver process.

Congressional Budget Office (CBO) Score Of The American Health Care Act
CBO and the staff of the Joint Committee on Taxation (JCT) estimate that enacting H.R. 1628 would reduce the cumulative federal deficit over the 2017-2026 period by $119 billion. They estimate that, in 2018, 14 million more individuals would be uninsured than under current law. The increase would reach 19 million in 2020 and 23 million in 2026. Now that a score exists, the Senate can address the AHCA from its perspective. A 13-member group was created by Majority Leader Mitch McConnell (R-KY) to begin work on the bill. Separately, Senators Bill Cassidy (R-LA) and Susan Collins (R-ME) are soliciting interest in forming a bipartisan group on a plan that would allow states to keep the Affordable Care Act (ACA) in place if they wish and also leave the ACA’s taxes and fees intact.
DEVELOPMENTS IN HIGHER EDUCATION

According to the budget that President Trump sent to Congress on May 23 for FY 2018, higher education also will be affected by proposed spending cuts. Along with ending subsidies for some undergraduate student loans and eliminating the federal Public Service Loan Forgiveness program, funding for the Federal Work-Study Program would be reduced by $490 million. Other provisions aimed at higher education include eliminating Supplemental Educational Opportunity Grants, allowing the Perkins Loan program to expire, and phasing out both the National Endowments for the Arts and Humanities. Spending that supports international education programs and exchanges, such as the Fulbright Scholar program, would be cut by 55%.

Regulatory Relief For Accreditation
The Council for Higher Education Accreditation (CHEA) released a Position Paper to offer proposals for the reduction of federal regulation of accreditation. Regulatory relief is viewed as central to achieving three major goals to move accreditation forward: (1) Protect students by strengthening accreditation rigor and providing expanded, readily understandable and accessible information about institutions and programs; (2) Advancing innovation by encouraging fresh approaches to quality review of traditional providers and expanding quality review to new providers and new credentialing; and (3) Sustaining accreditation strengths by maintaining and enhancing the academic leadership of institutions and programs, peer review, and the commitment to academic freedom.

Improving Transparency And Safeguarding Student Privacy In Higher Education
The U.S. House Subcommittee on Higher Education and Workforce Development of the Committee on Education and the Workforce conducted a hearing in Washington, DC on May 24, 2017. Some comments made by individuals who testified on that occasion are as follows:

Mamie Voight, Vice President of Policy Research, Institute for Higher Education Policy
Investing in a college education pays off. But while college is often a worthwhile investment, students, policymakers, and institutions cannot answer crucial questions about which programs at which institutions provide an adequate return on this investment. Through work with the PostsecData Collaborative we know our current postsecondary data infrastructure is a disjointed puzzle that needs to be improved.

Andrew Benton, President of Pepperdine University
Recognizing the importance of data both in informing consumer decisions and in ensuring institutional accountability, questions then become: What information is to be collected? How much is being collected? And, for whom and for what purposes is it being collected? In this age of attention to college pricing, he expressed concern about the cost burden of data collection.

Mark Schneider, Vice President and Institute Fellow, American Institutes for Research
Market competition works best when consumers can find and use clear, comparable information about the costs and quality of different offerings. If such information is lacking, either because it does not exist or because it is difficult to find and use, then market competition will be based on other attributes that may or may not be related to the key dimensions that enhance quality and efficiency.

Jason D. Delisle, Resident Fellow, American Enterprise Institute
Despite the ever-expanding benefits, loan types, and repayment options, delinquency and default rates suggest that the current system is not working. Over 8 million people are in default on their federal student loans today, a number that has continued to grow year after year, even though the country is now many years into an economic expansion with low rates of unemployment.
QUICK STAT (SHORT, TIMELY, AND TOPICAL)

Mortality Rate For African Americans
According to the Centers for Disease Control and Prevention (CDC), African Americans are living longer. The death rate for African Americans has declined about 25% over 17 years, primarily for those aged 65 years and older. Even with these improvements, new analysis shows that younger African Americans are living with or dying of many conditions typically found in white Americans at older ages. The difference shows up in African Americans in their 20s, 30s, and 40s for diseases and causes of death. When diseases start early, they can lead to death earlier. Chronic diseases and some of their risk factors may be silent or not diagnosed during these early years. Health differences are often due to economic and social conditions that are more common among African Americans than whites. For example, African American adults are more likely to report they cannot see a doctor because of cost.

Expenditures For Commonly Treated Conditions Among U.S. Adults Age 18 And Older
According to an Agency for Healthcare Research and Quality (AHRQ) Medical Expenditure Panel Survey Statistical Brief, in 2013, there were nine conditions that were cited as a reason for obtaining medical care for approximately 10% or more of the U.S. adult population. Among these conditions, treated prevalence ranged from about 10% for heart conditions and diabetes to about 25% for hypertension. The one-fourth of the adult population treated for hypertension (61.1 million adults), was more than twice the population that was treated for trauma-related disorders (12.2%), gastrointestinal (GI) disorders (11.8%), diabetes mellitus (10.0%) or heart conditions (9.7%). The second most widely treated condition was hyperlipidemia, which comprised about one-fifth (19.6 million) of the population, or 47.4 million adults. The next most commonly treated conditions were mental disorders (39.2 million adults; 16.2%), osteoarthritis/other non-traumatic joint disorders (38.1 million adults; 15.8%), and COPD/asthma (35.3 million adults; 14.6%). The most commonly treated conditions tended to be least expensive to treat.

HEALTH TECHNOLOGY CORNER

New York City Population Health Surveillance System
The NYC Macroscope uses electronic health records (EHRs) to track conditions managed by primary care practices that are important to public health. Using this system, it is possible to monitor in real-time the prevalence of chronic conditions, such as obesity, diabetes, and hypertension, as well as smoking rates. The NYC Macroscope relies on data from the Primary Care Information Project, which helps ambulatory providers in underserved areas adopt EHRs with population management tools to improve the quality of healthcare for the most vulnerable New Yorkers. The NYC Macroscope has been validated by comparing ambulatory EHR data with data from the 2013-14 NYC Health and Nutrition Examination Survey, a gold-standard, population-based health survey. Lessons learned in developing this tool will be useful to other agencies and researchers interested in using EHRs to monitor population health.

Direct 3D Bioprinting Of Prevascularized Tissue Constructs
As described in an article on the topic of direct 3D bioprinting of prevascularized tissue constructs that appeared in the April 2017 issue of the journal Biomaterials, nanoengineers at the University of California San Diego have 3D printed a lifelike, functional blood vessel network that could pave the way toward artificial organs and regenerative therapies. The new research addresses one of the biggest challenges in tissue engineering: safely producing lifelike tissues and organs with functioning vasculature. They created prevascularized tissues with complex three-dimensional (3D) microarchitectures using a rapid bioprinting method - microscale continuous optical bioprinting (μCOB). Multiple cell types mimicking the native vascular cell composition were encapsulated directly into hydrogels with precisely controlled distribution without the need of sacrificial materials or perfusion. The endothelial cells formed lumen-like structures spontaneously, demonstrating the survival and progressive formation of the endothelial network.
AVAILABLE RESOURCES ACCESSIBLE ELECTRONICALLY

Nutrition Across The Lifespan For Healthy Aging: Proceedings Of A Workshop

More than 46 million individuals over the age of 65 years were living in the United States in 2014 and more than 70 million are predicted by 2060. Education, living arrangements, and other demographic characteristics of this older population are changing, with noted variability by sex and race/ethnicity. Health status indicators, including life expectancy and heart disease death rates, have shown improvement, as have economic indicators. The National Academies of Sciences, Engineering, and Medicine’s Food Forum convened a workshop with objectives that included, examining trends and patterns in aging and factors related to healthy aging in the United States with a focus on nutrition; examining how nutrition can sustain and promote healthy aging, not only in late adulthood, but beginning in pregnancy and early childhood and extending throughout the lifespan; discussing changes in organ systems over the lifespan and changes that occur with age related to cognitive, brain, and mental health; and exploring opportunities to move forward in promoting healthy aging in the United States. The Proceedings can be obtained at https://www.nap.edu/read/24735/chapter/1.

Consumer Engagement In Health Care

A Notes article from the Employee Benefit Research Institute (EBRI) focuses on differences in consumer engagement in health care by millennials, baby boomers, and Generation Xers. Millennials are much more satisfied than baby boomers and Generation Xers with respect to several aspects of their health plan choices, and they are more satisfied than Generation Xers and baby boomers when it comes to financial aspects of the health plan. They also appear to be more engaged in picking a health plan, more engaged in cost-conscious health care decisions, and are more likely to engage in certain healthy behaviors. Millennials are more likely than baby boomers to report that various aspects of choosing a health plan are very important, but less satisfied with various non-financial aspects of their health coverage. The millennial generation numbers over 75 million, which is currently larger than the baby boom generation of about 74.9 million. Generation X is projected to pass the baby boom generation in size in about a decade. Employers are interested in the role of millennials in the labor force and how that might be different from the roles of prior generations. Employers should better understand how different workers may react to different plan design features and other efforts to engage workers in their health, and use of health care services. The article can be obtained at https://www.ebri.org/pdf/notespdf/EBRI_Notes_v38no6_CEHCS.27Apr17.pdf.

Use Of Wearable Tracking Devices In Wellness Programs

The Health Enhancement Research Organization (HERO) monitors emerging trends in the wellness field to identify best practice drivers of employee engagement, population health and well-being, and related financial and productivity outcomes. One of HERO’s major areas of focus is how improvements in employee health and well-being correlate with higher levels of workplace performance and productivity. The use of wearable activity tracking devices (wearables) is one of many technology-driven approaches currently being used to promote employee health and well-being. In the Fall of 2014 HERO launched The HERO Wearable Tracking Device Survey to better understand how employers are incorporating wearables into their health and well-being (wellness) programs, as well as to identify gaps in the current evidence base and opportunities for further research and application. A report about this endeavor can be obtained at http://hero-health.org/wp-content/uploads/2017/02/Wearables_Case-Study-Report_Final-2.pdf.
**CELLPHONE PENETRATION IMPACT ON HEALTH SURVEYS**

The second half of 2016 was the first time that a majority of American homes had only wireless telephones. The potential for bias due to under-coverage remains a real threat to health surveys that do not include sufficient representation of households with only wireless telephones. Preliminary results from the July–December 2016 National Health Interview Survey (NHIS) indicate that 50.8% of American homes did not have a landline telephone, but did have at least one wireless telephone (also known as cellular telephones, cellphones, or mobile phones), an increase of 2.5 percentage points since the second six months of 2015. More than 70% of all adults aged 25-34 and of adults renting their homes were living in wireless-only households. Some results of the survey are:

- Regarding alcohol consumption, the percentage of adults who had at least one heavy drinking day in the past year was substantially higher among wireless-only adults (29.8%) than among adults living in landline households (18.8%). Wireless-only adults were also more likely to be current smokers.

- Compared with adults living in landline households, wireless-only adults were more likely to have their health status described as excellent or very good, more likely to have met the 2008 federal physical activity guidelines for aerobic activity (based on leisure-time activity), and less likely to have ever been diagnosed with diabetes.

- The percentage without health insurance coverage at the time of interview among wireless-only adults under age 65 (13.6%) was greater than the percentage among adults in that age group living in landline households (7.7%).

- Compared with adults living in landline households, wireless-only adults were more likely to have experienced financial barriers to obtaining needed health care, and they were less likely to have a usual place to go for medical care. Wireless-only adults were also less likely to have received an influenza vaccination during the previous year.

- Wireless-only adults (46.1%) were more likely than adults living in landline households (36.9%) to have ever been tested for human immunodeficiency virus (HIV), the virus that causes AIDS.

**UNDERREPRESENTED MINORITY STUDENTS—SCIENCE AND ENGINEERING**

![Graph showing percentage of US undergraduate enrollment and S&E degrees by minority status, 2000 and 2012](image)

Sources: US Department of Education, National Center for Education Statistics, Digest of Education Statistics, Table 306.10. National Science Foundation, National Center for Science and Engineering Statistics, Women, Minorities, and Persons with Disabilities, Figure 3-A.