My unconventional path to medicine began as a junior in college, fresh from an internship at a bank and unsure if I would find a career in finance fulfilling. I enrolled in a journalism class that fall, and, for my final class project, wrote an article about music and medicine. As a jazz saxophonist, I was intrigued to learn about music therapy. I spent a day following the music therapist at a local rehabilitation hospital. The first patient we saw that morning was Gary, a 39-year-old patient recovering from a severe ischemic stroke. Gary could not say a word; he could only answer through subtle hand gestures and nodding or shaking his head. Even those small motions were difficult for him with his damaged motor function and aphasia. Once a young, healthy man, Gary now struggled to regain control of his voice and body. I wondered what he was feeling. Frustration? Anger? Hopelessness? Then, the music therapist picked up his acoustic guitar, and began to sing “Amazing Grace.” After one verse he asked Gary to sing along. Gary paused, then uttered his first words all session, “Amazing grace, how sweet the sound;” - the first verse to his favorite song. Chills rolled down my spine at what I had witnessed; through music, for a brief moment, Gary was transformed into the man he once was. I later learned that music therapy was part of Gary’s treatment plan under a medical specialty I had not yet heard of: physiatry. After speaking with a few physiatrists and doing my own research on the field, I realized that physiatry was that fulfilling future I was seeking.

I was fortunate to discover physiatry—this hidden gem of medical specialties—early. Many physiatrists often recount their exposure to the field as serendipitous, just as my encounter with Gary was. The discovery of physiatry, if it happens at all, is often late in a medical student’s career. In fact, it is not uncommon for medical students to graduate without any knowledge of the field at all.
But now, the secret is out. At this year’s AAP Annual Meeting, attendance from medical students reached a record high, representing 10% of the attendees. This year also marks the formation of the first ever national Medical Student Council, a group of seven medical students representing the medical student members of the AAP - and the future of the field.

The goal of the Medical Student Council is to continue to advertise the resources the AAP offers to students, including the mentorship program, the Medical Student Summer Clinical Externship (MSSCE), and the Rehabilitation Research Experience for Medical Students (RREMS) program (to which I credit my participation for my ultimate decision to pursue physiatry). We want to spur interest in physiatry across the country in hopes that all medical students are able to experience an important facet of patient care: maximizing quality of life.

Medical Schools are beginning to recognize the demand from students to learn about physiatry. That hidden gem is not so hidden anymore. The council hopes to be a voice for the next generation of physiatrists and continued awareness of the field. On behalf of the Medical Student Council, I am honored and excited to serve alongside you.

By: Bryan Le, MD '19, Chair of the AAP’s Medical Student Council

INTRODUCING THE AAP’S MEDICAL STUDENT COUNCIL!

Medical students are the future of our field, and cultivating early interest and mentorship is vital to its growth. That’s why we’ve created the first national Medical Student Council for students interested in physiatry. Representing medical student members of the AAP, our council will stimulate awareness and interest in pursuing physiatry as a career. Join us in celebrating the council’s inaugural leaders!

BRYAN LE 
CHAIR
Warren Alpert Medical School at Brown University

MEGAN KENNELLY 
MEMBERSHIP/ RECRUITMENT REPRESENTATIVE
University of Cincinnati College of Medicine

JUSTIN SCHNAPPELL 
VICE CHAIR
McGovern Medical School, UT Health at Houston

BARBARA KOZMINSKI 
SOCIAL MEDIA/ TECHNOLOGY REPRESENTATIVE
Saba University School of Medicine

LISA WIESENBERGER 
SECRETARY
Central Michigan University College of Medicine

GRETCHEN FERBER 
EDUCATION/ MENTORSHIP REPRESENTATIVE
Northeast Ohio Medical University

JACOB MOORE 
RESEARCH REPRESENTATIVE
AT Still University School of Osteopathic Medicine
Dear Colleagues,

The 2018 Annual Meeting in Atlanta was nothing short of a success. The number of registrants exceeded our expectations, sponsorship was at a record high, the educational programs left attendees wanting more, and our plenary speakers were enlightening. However, what impressed me most about the meeting was the energy generated by the quantity and quality of the engagement among our community. The advancement of academic physiatry occurs when our spheres of expertise and experiences intersect in this manner. This engagement continues beyond the Annual Meeting through ongoing formal activities of the numerous committees, councils and task forces and the board of trustees. Even more importantly, this engagement continues informally across the country because of the relationships that were started and built during the Annual Meeting.

As I embark on my second year as your President, I reflect often on our mission statement, “Creating the future of academic physiatry through mentorship, leadership, and discovery.” By mentorship, we mean more than just the transfer of data, skill, or even a trade. Mentorship is about personal transformation. While we most often think about the direction of this transformation from an established physiatrist to a trainee, in reality, this is bi-directional. Faculty has much to learn from our trainees so that we too are transformed. By leadership, we mean transformation beyond the academic department and even beyond the academic medical centers. In order to maximize the function and quality of life of persons with significant impairments and disabilities, society itself must be transformed. In transforming society, we need to link arms across our nation and across all nations so that our impact is global. Finally, by discovery, we mean more than the usual concepts associated with the word “research.” Yes, we need to contribute to evidence-based medicine by testing the validity of what we do today in practice. However, in discovery, there is a greater focus on innovation, where we are not bound by legacy or tradition, and we formulate and implement new and effective diagnostics and therapeutics.

When we provide commentary on our mission statement, we naturally gravitate toward these three methods – mentorship, leadership, and discovery - and for good reasons. But what about the front end? What do we mean by “Creating the future of academic physiatry?” Creating is an active process; it brings into existence or causes a new state. While this new state, such as “the future of academic physiatry,” sounds nice in a mission statement, a new state indicates change, and we don’t like change! We are willing to tolerate change when we have no choice; that is when a threatening environmental perturbation is already in our midst. Change in anticipation of a future environmental perturbation, or proactive change, is more difficult and requires greater degree of socialization, but we generally recognize that this is a better change management strategy. Unfortunately, in either case, change still tends to be more incremental than not. If we are to be free from the bondage of always having to respond to an environmental perturbation, whether present or anticipated, our change must be discontinuous or disruptive. In this way, we create the future of academic physiatry where we dictate terms, where we thrive and not just survive. It is often stated that “we must plan for and be where the puck will be.” But this assumes that someone else is hitting the puck. Why can’t we hit the puck? It also assumes that the puck will remain in the confines of the ice rink. Why must we be constrained by the rink? And so, I invite you to put your thinking caps on, especially those whose synaptic flexibility remains high, ignite your spirit of volunteerism, and engage your Association to formulate and implement disruptive change to ensure a bright future for academic physiatry.

Sincerely,

John Chae, MD
President of the Board, Association of Academic Physiatrists
5 FAVORITE TESTIMONIALS

1. “The educational content at the @AAPhysiatrists annual meeting is unrivaled.”
   Miguel Escalon, MD

2. “The environment at the AAP is always supportive, positive, and educational. It is by far my favorite conference.”
   Daniel Cushman, MD

3. “I always come away from AAP with a mental springboard for new ideas and projects to implement.”
   Jeffrey Fine, MD

4. “I am always in awe of all the incredible people I get to meet and interact with at @AAPhysiatrists meeting. From staff, to med students, to residents, to fellows, to attendings… I feel so motivated and inspired.”
   Allison Bean, MD, PhD

5. “I joined the AAP as a resident in 1999. The annual meeting is by far my most favorite professional gathering. The opportunities to catch up with friends, collaborate on projects, or spawn new ideas are endless.”

TOP 5 SPONSORS

MERZ NEUROSCIENCES™  Allergan  SAOL THERAPEUTICS  MetroHealth  IPSEN
WE’RE CELEBRATING

Over 1,170 attendees came from 14 different countries

275 speakers and 522 poster presenters showcased the finest advances and thinking

Launched our first philanthropy project, making capes and cards for children in local hospitals

Social media stars: 548 posts about #Physiatry18 with over 100,000 impressions

100% of survey responders would recommend it to a colleague

AWARD WINNERS

1. Karen Kowalske, MD Distinguished Academician
2. Sabrina Paganoni, MD, PhD Early Career Academician
3. Yannick Benjamin Public Service Award
4. Alex Elegudin Public Service Award
5. Brittany Bickelhaupt, MD McLean Outstanding Resident/Fellow Award
6. Laura Kezar, MD Outstanding Service Award
7. Vu Nguyen, MD Outstanding Service Award
8. Jennifer Zumsteg, MD Innovation & Impact Award

5 REASONS TO ATTEND PHYSIATRY ‘19

1. Puerto Rico! Sparkling sun, clear blue water, 400+ years of history and tradition… Need we say more?
2. The meeting will feature even more hands-on, interactive and skills-based educational sessions
3. Our learning pathway will focus on the leading causes of disability globally (musculoskeletal disorders)
4. A conference with a cause – we’ll offer a philanthropy project that gives back to the local community!
5. There are many ways to get involved: present, exhibit, sponsor, nominate, learn, collaborate!

5 (OKAY, 8!)
In the United States, medical school education is expensive. Data from the Association of American Medical Colleges (AAMC) for the academic years 2017-2018 indicate that the average annual tuition for first-year students attending public medical schools is $31,202 for state residents and $55,040 for non-residents. For those attending private medical schools, the tuition is $52,558 and $53,914 respectively. These costs do not include non-tuition fees, health insurance, or room and board, which add thousands of dollars annually. The duration of medical school education is typically four years and could be longer if a student selects additional degrees, such as MPH or PhD. The data from the AAMC indicates that the mean allopathic medical education debt at graduation is $190,694 for the class of 2017, while the American Association of Colleges of Osteopathic Medicine (AACOM) data indicates that the average osteopathic medical education debt is $240,331 for the class of 2016. The median four-year costs of attendance for an in-state resident member of the class of 2018 in a public medical school is $243,902 (up by 1% from the previous year) and in a private school is $322,767 (up by 3% from the previous year). Both figures include cost for non-tuition fees, health insurance, room and board, and other collateral expenses, but do not include debt that might have been incurred in undergraduate education. Marcu et al report that “institutional scholarships can reduce this burden, but the median four-year award is only $18,000” and that “less than one in five students receives $100,000 or more in financial assistance from any source.” They further state “only about 5% of matriculating students secure a federally funded national service scholarship” and “most borrow to pay part or all of the cost of their education.” Marcu et al noted that “since 1987, approximately half of U.S. medical students have come from the richest quintile of household incomes; the proportion of students from the poorest quintile has not exceeded 5.5%” and that “more than 80% of students finance part or all of their medical school education with loans. For the class of 2016, the median debt owed by new graduates was $190,000. Thirteen percent owed $300,000 or more.” During the transition to residency training, there are additional costs for examinations as well as for interview trips, which could add several thousand dollars more to the overall cost of attending medical school. The length of residency training varies from 3 years for primary care to 7 years for neurosurgery, for example. Some trainees seek additional education through fellowship programs, which add an additional 1 or 2 years beyond residency. The yearly compensation of residents and fellows is a small fraction of a practicing physician salary. Career choices are based on more than economics. However, the magnitude of debt burden has led many to consider whether a career in primary care is still financially viable. An article from Youngclaus et al concludes that a “primary care career remains financially viable for medical school graduates with median levels of education debt.” There are several options available to medical students to manage their debt.
The Liaison Committee on Medical Education (LCME) accreditation of medical schools covers programmatic standards which are directly related to financial aid. These standards include the requirement that “a medical school provides its medical students with effective financial aid and debt management counseling and has mechanisms in place to minimize the impact of direct educational expenses (i.e., tuition, fees, books, supplies) on medical student indebtedness.” (7) Non-compliance of these standards jeopardizes the accreditation of the medical school.

On a larger scale, some national leaders in medicine are considering the potential benefit of reducing medical education to 3 years from 4 years for select groups of students, thus reducing the cost of medical school education by approximately 25% and helping to improve the national physician shortage situation. (8) A key consideration is the importance of selecting students who know what they want to do after graduation. Some three-year programs such as one at NYU School of Medicine essentially combine the fourth-year with the preliminary year of residency to help reduce student debt. Another area for consideration is the need to delete scores for USMLE to a Pass-Fail system. Many students spend large sums of money to purchase study materials to keep improving their USMLE Part 1 scores by re-taking the test in order to remain competitive in the residency application process.

The “elephant in the room” is USMLE Step 3, which costs $850 in 2018 and passage of this test is mandatory for licensure of any U.S. physician. This test mainly covers Medicine, Pediatrics, OB Gyn, Surgery, and Biostatistics. It has over a 97% first-time pass rate in 2016, which is the latest publicly available data. (9) Moreover, many specialties are no longer requiring an “initial general year” and the graduated medical students go directly into their specialty. Today, this examination appears to serve little purpose except it is required by every state medical board for licensure. It does bring substantial income into the State Medical Boards and the National Board of Medical Examiner, which governs the USMLE process. We believe this examination should be eliminated, however, this process improvement would require the modification of all the states medical practice acts.

Despite the financial cost of attending medical school, the AAMC survey found 75% of the graduating seniors felt that they were satisfied or very satisfied with their medical school training. As suggested by Prescott et al, “medical education, while expensive, remains the good career investment. An MD degree can lead to a lifetime of personal fulfillment and societal contributions. Everyone, with rare exceptions, accepted to a U.S. medical school will be able to finance their medical education via a path that aligns with their personal values and priorities.” (6) However, “with debt increasing much more rapidly than physician incomes, a continued increase in the fifth quintile percentage would be a warning that medical education is becoming increasingly out of reach for applicants of modest means.” (10) The AAMC strives for a medical workforce that reflects the population demographics. Unfortunately, the cost of medical education rarely is part of this discussion.

REFERENCES
The two-day Residency and Fellowship Program Directors (RFPD) Workshop at Physiatry ‘18 attracted 125 program directors and 37 program coordinators for lively, timely and collegial discussions. Here are the highlights:

• A dynamic trio from ACGME, Caroline Fisher, David Pruitt, and Laura Edgar, shared the new version of the common program requirements, an update regarding the Residency Review Committee structure and processes, and the promise of the next iteration of PM&R Milestones (2.0).

• Anthony Chiodo, Chairman of ABPMR, discussed the distinct mission of the board, service and academic activities of various board committees, the CertLink pilot status, and the need for volunteers.

• Michael Saulino entertained with his perennially popular resident recruitment presentation. Using real-time data from a variety of disparate sources, Dr. Saulino provided evidence of physiatry’s appeal to medical students and discussed practical recruitment implications.

• Armed with financial data and t-shirts flying over the audience’s heads, Vishwa Raj and Greg Worsowicz highlighted tensions between the current GME funding sources and graduating residents’ and fellows’ job opportunities.

• Sara Cucurullo masterfully conducted the RFPD business meeting, recruiting Vu Nguyen, MD as the next Organization of Program Director Associations (OPDA) representative, and Anne Felicia Ambrose, MD as the new Secretary for the RFPD Council.

The second day was dedicated to a critical issue in the medical field – physician wellness. Dr. Timothy Brigham from ACGME gave a comprehensive and moving discussion of physician wellness and burnout, and its’ dire consequences. Subsequently, using 5 questions prepared by the RFPD Council planning group, Dr. Brigham utilized ‘interview design’ to construct the group’s views on wellness in physiatry. Changing seats and group work followed, and culminated in the presentation of the participants’ answers. Preliminary results can be found below and will be used by RFPD Council leaders to propose action items to the AAP’s membership and leadership. Do you have ideas on how to practically improve physician wellness? Share your insights with the RFPD Council at aap-programdirectors@googlegroups.com!

1. When you’re working, what makes you feel most alive and engaged?
   • advocacy
   • being involved in research/seeing it through
   • changing lives (learners, patients, staff)
   • concept of ‘TEAM’/collaboration
   • deeper connection to other’s lives
   • earning trust
   • educating learners
   • having enough sleep
   • positive feedback
   • problem solving
   • promoting passion
   • task completion
   • understanding actual role of program coordinator/program director

2. What diminishes your well-being and causes you the most frustration about the practice of medicine (or physiatry)?
   • emotional exhaustion- not feeling that I’m caring for patients
   • EMR
   • isolation
   • judged about priorities
   • lack of autonomy
   • professional burden encroaching on family/personal life
   • regulatory burden
   • spread too thin
   • undervalued/not appreciated
Welcome back from Atlanta! All of the lectures, speakers and networking opportunities were dynamic and invaluable. Cindy Volack is already on the hunt for you to showcase your knowledge and skills at Physiatry ‘19 in Puerto Rico, February 19-23, 2019. Let her know if you are interested in presenting at volackc@nyp.org.

One important topic (among the many!) discussed was ACGME resident wellness requirements. Cindy Volack and Patti Hayden gave helpful ideas for developing and meeting the requirements, including:

• Meetup.com
• Pages about wellness in the institution health plan or employee assistance program
• Maslach Index for Burnout - http://www.mindgarden.com/117-maslach-burnout-inventory
• Physician Well-Being Index - https://www.mededwebs.com/well-being-index
• Inventory of Elements of Your Program’s Well-Being Plan from ACGME - http://bit.ly/WellbeingInventory

NEW COMMON PROGRAM REQUIREMENTS – EFFECTIVE JULY 1, 2019
The new Common Program Requirements (CPRs) for Section I-V will be effective on July 1, 2019. The proposed new CPRs are current undergoing the review and comment phase. But be prepared by taking time now to get familiar with the proposed changes and ways you can implement. The proposed new CPRs can be found at www.acgme.org.

NEW COMMON PROGRAM REQUIREMENTS – EFFECTIVE JULY 1, 2017
The new CPRs for Section VI are in effect! View the Implementation Table at http://bit.ly/CPRimplementation to determine which of these requirements to work on first. Not all were required to be in place July 1st, but most were. You can also find FAQs at http://bit.ly/CPRfaqs.

We look forward to the ideas shared and the friendships made among Program Coordinators! Reach members of our Council and get involved anytime.

Chair: Tammie Wiley Rice
twiley@med.umich.edu
Chair Elect: Nicole Prioleau
npriolea@jhmi.edu
Program Director/Secretary: Cynthia Volack
volackc@nyp.org
Past Chair: Coretha Davis, BS
cdavis@med.miami.edu
Newsletter Editor: Stacey
sneadpetersons@upmc.edu

3. What is under our control as individuals and as a community of physiatry specialists that we could do to positively affect our well-being?
• communication- listening, being heard, valued
• faculty and resident advocacy and community activities
• self-awareness- positive role models, mentoring, setting limits, priorities
• administration- professional development, regular review of duties/activities/priorities
• team building/wellness activities
• teamwork with similar goals

4. In your opinion, what are the most important things that need to be done in order to achieve a clinical learning environment that supports and nurtures physician well-being?
• active participation in structure of our day
• admission of feeling overwhelmed- safe environment to say “I need a break”
• advocacy for government and university
• attending support- residents feel supported
• communication, including styles/feedback and teaching styles
• concierge service for personal “chores” (such as an oil change)
• easy access to healthcare
• EMR and increasing regulations impede teaching/learning
• focus teaching
• increased regulations increase stress and decrease well-being
• mentor pairing
• physician leadership training
• not enough time for doctor-patient relationship
• protected administrative time-teaching time, research time
• set expectations: “what do you (resident) want to learn today?”
• lectures followed by Q&A
• QI efforts- data-driven outcome measurement

5. Where do we need allies outside of physiatry to effect change? Who are they and how do we best involve them?
• administration- involving GMEC and employee assistance program
• allied health- involvement of interdisciplinary committees
• cross-training with other residency programs
• Dr. Brigham and ACGME
• high profile patients/ government officials/media
• national medical societies - borrowing methods adopted by other specialties/systems
• patients/community- educational efforts to public
• payors/regulators/pharma- advocacy in DC/state
• philanthropic organizations
• psychologists
• tech innovators
• unions
CONGRESS COMES TO AGREEMENT ON SPENDING AND HEALTH CARE PROVISIONS

The Bipartisan Budget Act of 2018 was signed into law by President Donald Trump on Feb. 9, 2018, which extended funding for the federal government into March to avoid a government shutdown, but also a number of health care related provisions. On the budget front, the bill establishes a new budget agreement for the next two years allowing appropriators to avoid sequestration, which called for across-the-board cuts to government spending. The agreement extends current government funding to March 23rd and allows Congress the ability to add an additional $63 billion in nondefense discretionary spending for Fiscal Year 2018. Congressional leaders have publicly stated they would set aside $1 billion of the new funding for an NIH increase for both FY 2018 and 2019. The NIH could potentially receive more given the increase in budget caps for both years.

In addition to spending provisions, the Bipartisan Budget Act of 2018 included numerous changes to Medicare and health care policy. For starters, the bill permanently repeals the Medicare caps on outpatient therapies and other rehabilitation services. The repeal was enacted before beneficiaries were set to hit the $2,010 therapy cap. The therapy cap put more than a million beneficiaries at risk of losing access to outpatient Medicare Part B therapy services.

Since the passage of the Balanced Budget Act in 1997, beneficiaries have faced a limitation on the amount of occupational therapy, physical therapy, and speech-language pathology they could receive under Medicare Part B. Congress has routinely suspended the caps from year to year but has now decided to abolish them altogether. The legislation also abolished the Independent Payment Advisory Board (IPAB), which was created in the Affordable Care Act (ACA). IPAB was wildly unpopular with providers as it would have allowed for provider payment cuts without Congressional approval.

The Act also added provisions specific to stroke and rehabilitation patients. It adds Medicare payment for stroke telemedicine services, as outlined in the Furthering Access to Stroke Telemedicine (FAST) Act. This would allow Medicare coverage of telestroke services (remote evaluation and treatment) no matter where the patient is located. Current law allows those services only in certain rural areas. The bill also increased the number of team members allowed to provide cardiac rehabilitation services. Specifically, physician assistants, nurse practitioners and clinical nurse specialists are now allowed to supervise cardiac and pulmonary rehabilitation on a day-to-day basis under Medicare.

TRUMP BUDGET PROPOSES BIG CHANGES TO REHAB ENTITIES

Each year the President proposes his plans for the federal government in the form of their proposed budget. This budget provides some insight into the administration’s policy proposals, but Congress has the ultimate say. In their proposed budget, the White House made several suggestions to reorganize how the federal government handles their rehabilitation research portfolio. The proposed budget transfers the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR) to the National Institutes of Health (NIH), which they believe complements existing NIH research portfolios addressing disabilities and aging. The budget provides $95 million for these activities, which is $8 million below the FY 2018 Continuing Resolution.

The Trump plan would also transfer the National Institute of Occupational Safety and Health to the NIH from the Centers for Disease Control and Prevention, including the Energy Employee Occupational Injury Compensation Act program. This and NIDILRR would be included in the NIH budget as separate entities. It also calls for NIH to assess the feasibility of integrating health services research activities more fully into existing NIH Institutes and Centers over time. To date, Congress has not expressed an interest to take up the administration’s proposal to reorganize rehab research and the AAP will continue to follow this issue closely.
Nominate the leading physiatry professionals in your life to win a coveted AAP Award at Physiatry ‘19!

From distinguished academician and outstanding resident/fellow to public service and innovation, the AAP’s annual awards celebrate the most impactful in the AAP, the field and the community.

Nominations will be accepted April 4 – June 6, 2018 at www.physiatry.org/AAPawards! Winners will be honored at the AAP’s 2019 Annual Meeting, February 19-23, 2019 in Puerto Rico.