Two important articles were published in December 2015 that I believe must be required reading by all Department Chairpersons, Residency Program Directors, and Medical School Clerkship Directors. They are:


The extremely important, well written article on burnout (1) concluded that burnout and satisfaction in U.S. physicians worsened from 2011 to 2014 (P=.01). For these physiatrists who responded, satisfaction that work leaves enough time for personal and/or family life decreased slightly from about 42% to 40%. This is despite no increase in the median number of hours worked per week. These are very frightening trends, especially with the aging population and its healthcare needs/demands.

The article points out that to reverse this trend, it will require an effective response at the individual level, the organizational level, and the systems level. There is a need to improve the efficiency and support in the practice environment. The AAP can and should provide courses on stress management, time management, and how to help physiatrists establish...
principles that help facilitate work-life integration as well as perform their own wellness. Burnout among physicians has to have a negative effect on quality of care, patient satisfaction, turnover, and patient safety. Also with respect to their academic duties, what will be the impact of faculty burnout on residents? I suspect that the current administrative paper volume and the documentation demands play a significant role in burnout.

The second paper by Mata, et-al, estimates a prevalence of depression or depression symptoms among resident physicians was 20.9% to 43.2%, depending on the instrument used. None of these studies specifically addressed physicians. I believe that organized medicine, medical schools, and professional societies need to look at the entire spectrum of physician medical education. It should be helpful during the medical school admission process that there is a reliable method to determine how the applicant handles stress. In medical school there needs to be a method to identify students who are not handling stress properly and provide them with counseling, including “time out.” With respect to residency/fellowship training, PM&R Residency Program Directors need to critically study this issue and develop constructive approaches. I would like to see stress management being a mandatory part of the ACGME PM&R requirements. Maybe there should be monthly open forums in each residency to discuss issues such as these. I believe the PM&R-RRC should be the leader in bringing these issues to the entire ACGME. It fits into the rehabilitation/prevention concept.

I would like to congratulate these authors for raising these issues. I hope that our specialty will provide the leadership necessary to respond and reverse this trend.

AAP’s PM&R Fairs for Medical Students

AAP’s PM&R Fairs Grant Program is a new initiative that aims to provide medical students a hands-on look into the world of physiatry. This past fall, Rutgers-New Jersey Medical School/Kessler Physical Medicine and Rehabilitation Department and University of Pittsburgh Medical Center (UPMC) hosted successful PM&R fairs for medical students funded by AAP’s new program.

UPMC welcomed approximately 60 medical students from five different campuses across three states to participate in hands-on work stations demonstrating some of the unique tools and techniques of the field. Kessler’s medical fair hosted over 70 medical students and followed a similar approach offering interactive demonstrations following a light networking dinner, brief introduction from the chair, and a virtual tour highlighting rehabilitation and research at Kessler Institute and the Kessler Foundation. Medical students at both institutions rotated through physiatry demonstration stations that spanned ultrasound/EMG, assistive technology and wheelchairs, spasticity management, prosthetics and orthotics, physical and occupational therapy, and more!

Participant feedback from both PM&R fairs was very positive. At Kessler, 100% reported enjoying the fair “very much,” 94% reported being more likely to apply to PM&R residency after attending the fair, and 100% would recommend attending the fair to students interested in PM&R. At UPMC, nearly half of the attendees indicated an interest in finding a mentor within physiatry following the fair.

For more information on the PM&R Fair grant program, contact Member Services Manager Amy Schnappinger at 410-614-1000 or aschnappinger@physiatry.org.

MESSAGE FROM THE PRESIDENT

AAP had an amazing year in 2015 – we have a lot to celebrate! Every success we enjoy is because of your support, talented contributions, and dedication to mentorship, leadership, and discovery in academic physiatry. You will soon receive AAP's Annual Report which will detail AAP’s activities throughout the past year, but I wanted to also highlight a few of our accomplishments in 2015.

Record Breaking Membership Numbers and Annual Meeting Attendance – A growing AAP means greater recognition of physiatry among the medical community, more resources and support for our members, and a larger network of medical professionals dedicated to mentorship, leadership, and discovery in academic physiatry.

Public Policy Committee & Hill Visits – AAP launched a Public Policy Committee and hired talented lobbyists to advocate for rehabilitation research and GME. Chair of the Public Policy Committee, John Whyte, MD, PhD and myself visited the Hill for 2 packed days of meetings with government officials to help spread the word about physiatry and advocate for our cause.

AAP Virtual Campus – We also launched the AAP Virtual Campus, your on-demand resource for comprehensive information and education, offering CME articles published in AAP’s leading “blue journal,” AJPM&R, academic development podcasts, a step-by-step ‘Research Badges’ guide to conducting research in physiatry and publication, and Annual Meeting CME activities. We look forward to developing more virtual educational opportunities for academic physiatrists in 2016.

Program Growth – In 2015, we had increased participation in all of AAP’s renowned programs such as the Program for Academic Leadership (PAL), RMSTP, our medical student externship programs – PREMS and MSSCE, the Physiatric Research Consulting Program, and PM&R medical students fairs.

2015 was not only a great year for AAP, it also marked the momentous occasion of the 25th Anniversary of the Americans with Disabilities Act (ADA). On December 3rd, 2015 AAP joined the rest of the world in celebrating the International Day of Persons with Disabilities. Since 1992, this occasion commemorates critical issues relating to the inclusion of persons with activity limitation and participation restriction in society. Through research we, as academic physiatrists, can do a lot more in enhancing rehabilitation outcomes and community integration through restorative therapies and application of novel technologies. We can also promote awareness and educate the public, including our other professional colleagues in clinical medicine and medical education, on matters about chronic disability management. We have come a long way since the enactment of the Americans with Disabilities Act (ADA) 25 years ago, but we still have a long way to go.

Personally, I am fortunate that I do not have to travel far to learn more about the past, current, and future challenges of persons with activity limitation and participation restriction. Not far from my office Lex Frieden, professor of bioinformatics and rehabilitation at the University of Texas Health Science Center at Houston McGovern Medical School, and Director of the TIRR Memorial Hermann Independent Living Resource Utilization, holds court. I invited Lex, a renowned educator, researcher, disability policy expert and widely acknowledged as “a chief architect of the ADA,” to write down his musings about what we have accomplished in disability rights and empowerment.

Enjoy reading his piece on the following page of this newsletter, and join me in hoping that one day the term “disability” will be archaic and that instead we will celebrate the "International Day of Persons with Enhanced Abilities!"
CONSIDER WHAT WE HAVE ACCOMPLISHED

By Lex Frieden

Twenty-five years ago, President George HW Bush lifted his pen and signed the Americans with Disabilities Act of 1990 (ADA) into law. It was a momentous occasion, with more than 3,000 people with disabilities and advocates on the South Lawn of the White House holding their collective breath, then cheering loudly, as history was made and lives were changed.

I broke my neck in a car accident when I was a freshman in college, in 1967. Less than a year after that, I was denied admission to a major university on the basis of my disability. I was told that there was nothing wrong with my academic qualifications: I had been valedictorian of my high school and I had nearly perfect national achievement test scores. The problem, they said, was that I used a wheelchair and the university had a policy not to admit students with disabilities.

For hundreds of years, people with disabilities were denied opportunities to engage in education, employment, recreation, and many other endeavors, simply because they had physical, sensory, cognitive or other impairments. When I left the rehabilitation center where I was treated following my accident early in 1968, there were many steps that I could not get up and narrow doorways that I could not pass through. To the extent possible, I found alternate pathways to get where I wanted to go. In the case of the university where I applied, virtually all the buildings on the campus were newly built, and comparatively accessible. In that case, physical and environmental barriers did not stop me and scores of others from going to the university: misguided beliefs, prejudice, fear and hatred did. Discrimination is far more hurtful when it is based on senseless policies and personal prejudices than when it results from physical barriers.

Since the ADA was enacted, the environment has changed radically. Now there are ramps where there once were steps and wide doorways where there used to be narrow ones. Most buildings and facilities used by the public are fully accessible. Accommodations are now routinely made for people with disabilities in education, employment, transportation, communications, recreation, and public services. While discrimination may still deprive individuals the benefits of full participation and equal opportunity because they have a disability, the ADA deems such action unlawful. My life and the lives of nearly 56 million other people with disabilities in the US has improved as a result of the ADA.

The ADAs impact has been felt around the world. When President Bush signed the law, he said that he expected other countries to adopt similar legislation. Three months after that, I had the distinct honor of meeting the President of China at the Great Hall of the People in Beijing and visiting with him about an ADA-like initiative in China that had been inspired by Deng Pufang, the son of the renowned Chinese leader, Deng Xiaoping. Deng Pufang was spinal cord injured and disabled when he was pushed out a third story window at his university. Despite his status and prominence, Mr. Deng experienced discrimination resulting from his disability. Like thousands of enlightened disability rights advocates around the world, Mr. Deng believed that nondiscrimination on the basis of disability should be a universal precept. He and many other colleagues promoted the concept of an international disability rights law.

The product of years of work by organizations of people with disabilities and disability experts from every continent, the Convention on the Rights of Persons with Disabilities (CRPD) was put into force by the United Nations General Assembly on May 3, 2008. The CRPD is an international treaty protecting people with disabilities from discrimination and establishing certain bases for protection and treatment of people with disabilities across a wide range of social and cultural activities.

There are more than a billion people with disabilities in the world today. The CRPD has already had a profound effect on many of their lives. But, like people with disabilities in the US who have enjoyed improvements prompted by the ADA, many barriers to independence and full inclusion remain for people with disabilities, regardless of where they live. The World Health Organization reports that people with disabilities face disparities in employment, community living, and health care. Perhaps not surprisingly, rehabilitation is one of the greatest needs. Suffice it to say, for people with disabilities to realize the vision of advocates and policymakers who produced the ADA and the CRPD, they must have access to and services and supports from rehabilitation providers.

While work remains to be done, we should step back from our work, take a short break from our everyday routine, and take a moment to celebrate the progress we have made toward enabling people with disabilities to be full participants in our communities and to contribute to our society, our economy, our culture and our world. By helping to ensure that everyone has an opportunity to contribute and to be full participants in the mainstream of life, we have helped to make the world a better place for all of us to live. Through our work, and through historic efforts like the Americans with Disabilities Act and the UN Convention on the Rights of People with Disabilities, people with disabilities now have access to places where they could never before go, and they can accomplish things about which they once could only dream.

Lex Frieden (Lex.Frieden@hhs.gov) is professor of biomedical informatics and rehabilitation at The University of Texas Health Science Center at Houston. He also directs the Independent Living Research Utilization Program at TIRR Memorial Hermann. Frieden has served as chairperson of the National Council on Disability, president of Rehabilitation International, and chairperson of the American Association of People with Disabilities. He was instrumental in conceiving and drafting the Americans with Disabilities Act (ADA) of 1990.

"My life and the lives of 56 million other people with disabilities in the US has improved as a result of the ADA."

Who’s Who in the AAP Office?

Bernadette Rensing

Bernadette Rensing is the External Affairs Manager of the Association of Academic Physiatrists (AAP). She has enjoyed working with AAP for over 5 years, starting as the Communications Manager in 2010. She graduated from James Madison University’s College of Business with a BS in Marketing. Prior to joining AAP, Bernadette was the Assistant Marketing Director for CERT Health Sciences in Baltimore, MD for 2 years. CERT Health Sciences’ flagship product is a non-surgical spinal decompression system called SpineMED. It was here that Bernadette first started working with physiatrists and became familiar with the wonderful specialty of PM&R. Before SpineMED, Bernadette spent 3 years in marketing and sales for Madison Avenue in Columbia, MD where she worked closely with corporate and association meeting planners. Bernadette enjoys spending time with her husband Gabie, and playing sports and Minecraft with her 6-year old son Finn.

3 Things People Don’t Know About Me:

1. I am really good at juggling.
2. Growing up I was the proud owner of dozens of pet frogs, lizards, turtles, and snakes.
3. I once got lost on a jet ski for hours until my husband and a coast guard located me, and had the best time!
Advocacy Update

NIH Appropriations

Just before adjourning for the year Congress passed, and the President signed, a $1.1 trillion omnibus spending package to fund the government for FY 2016. Among the spending provisions in the bill, the National Institutes of Health received $32 billion. This represents a $2 billion increase over FY 15 funding levels. This is the largest increase NIH has received in more than a decade.

A key investment of the omnibus spending bill includes $150 Million for the BRAIN Initiative. The bill provides an $85 million increase for the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative, bringing the total investment to $150 million for the coming year. The BRAIN Initiative will map the human brain to help researchers better understand and treat brain disorders such as Alzheimer’s and Parkinson’s diseases, traumatic brain injury (TBI), and depression. In addition, the measure increases funding for every Institute and Center.

In addition to the NIH increase, the spending bill eliminated 18 federal programs, including preventing the administration from using discretionary funds to bail out the Affordable Care Act (ACA) Risk Corridor program as well as defunding the ACA Independent Payment Advisory Board. In addition, the omnibus included a two year suspension of the 2.3% Medical Device Tax through 2017 (tax to take effect in 2018) and a two year moratorium on the employer-sponsored healthcare insurance “Cadillac Tax.” Both taxes were revenue-raising provision included in the Affordable Care Act (ACA). Although the 2.3% Medical Device Tax has received more national attention as a key target of the repeal, the “Cadillac Tax” has steadily garnered a strong level of opposition since the ACA was enacted in 2010.

MedPAC

The Medicare Payment Advisory Committee (MedPAC) released comments on CMS’s development of discharge to community and potentially preventable readmission measures. These measures are required by the Improving Post-Acute Care Transformation (IMPACT) Act of 2014 and the Protecting Access to Medicare Act of 2014 and aim to reflect the quality of care furnished in the four post-acute care (PAC) settings—home health agencies (HHAs), skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). MedPAC supports the development of these measures, and in its own open forum has used measures to evaluate the quality of care in SNFs and IRFs.

MedPAC recognizes the importance of cross-cutting measures to gauge and compare the quality of care across PAC settings and finds it critical the measures use a uniform definition, specification (such as inclusions and exclusions), and risk adjustment method. MedPAC believes providers should be held accountable for the care they furnish during “their watch” and for safe transitions to the next care setting or home, and their comments focus on additional measures needed to assess both aspects of care and ways to standardize the measures so that rates reflect actual differences in care and not the measure specification. MedPAC’s full letter with comments to CMS can be found here.

CDC Asks for Comments on Opioid Prescribing Guidelines

The CDC released draft opioid guidelines in late December and have asked for public comment regarding the guidelines. The guidelines have received significant criticism from the medical community who argue that they were based on thin evidence and created largely without outside input. The guidelines fall into three categories: when to start or continue prescribing opioids for chronic pain; opioid selection, dosage, follow-up and discontinuation; and assessing risk and harms of opioid use. The draft guidelines are based on CDC’s determination that “no evidence” shows a long-term benefit of treating chronic pain with opioids. The agency asserts that “evidence” shows potential harms, including abuse and addiction, overdose and heart attacks, and that “evidence” suggests benefits of alternative treatments with less risk of harm.

The voluntary guidelines are to be applied to the treatment of pain outside of end-of-life, palliative or cancer care. They’re intended to limit opioid prescribing for non-cancer related pain, which the CDC says is the primary driver of the nation’s opioid abuse and overdose epidemic. The public comment period for the guidelines opened December 14, 2015 and closed January 13, 2016.

Interview with Resident/Fellow Council (RFC) Alumni Emerald Lin, MD

Conducted by Lisanne Cruz, MD

How has your experience with the RFC impacted your career?

It has been a great way to develop leadership skills, foster collaboration between programs nationally, meet leaders in the field, and influence the conference program. Being part of the AAP as a resident and fellow inspired me, and taught me how to do these things and beyond. Working closely with other RFC members from across the country has fostered long lasting friendships and working relationships. Furthermore, it has provided me with the inspiration and experience that lead me to be me today.

What do you do now?

I was one of the three physiatrists at the Traumatic Brain Injury Clinic at the Fort Belvoir Community Hospital in Virginia, which provides medical care to active duty service members of all military branches. I was the traumatic brain injury center’s medical director, helped develop the botulinum toxin injection clinic, and was the educational program director for the interdisciplinary staff. Next, I will be joining the Physiatry Department at the Hospital for Special Surgery, where I will help build the multidisciplinary concussive clinic, and manage general musculoskeletal conditions and spasticity.

I was previously the President-Elect of the New York Society of Physical Medicine and Rehabilitation. This year I have advanced to the role of President. We have a great contingent of physiatrist members at all levels of training, including medical students. Similar to the AAP, this is our local organization, in which members participate in multiple events including CME lectures, volunteering, advocacy and workshops.

Would you recommend residents get involved with the RFC, if so, why?

I would definitely recommend that residents get involved! It is an excellent opportunity to see things “outside the box” of how things are done in your home institution, create new and lasting connections, develop leadership skills, and create new opportunities. In my conversations with fellow RFCers, one of the values of the RFC is to discuss novel ideas, develop them, and execute them on a national level. Many of us transitioned to AAP governing committees after graduating from residency/fellowship, and thus the RFC. The RFC provided me with the experience, understanding, and confidence to provide meaningful contributions at the next level. Additionally, the AAP is made up of a tighter knit group of academicians. It is in very few other organizations where residents can sit down randomly at a lunch table and strike up a conversation with a program director, fellowship director, or even chair.

Nominations for RFC leadership positions are accepted each December and elections take place at the AAP Annual Meeting. Visit physiatry.org for more information.
THE SIX THINKING HATS

Edward de Bono developed the six hats as part of a tool designed to help you think about your work from different perspectives. The “six thinking hats” tool helps groups and individuals look at situations from different perspectives in order to gain insight on effectively tackling a problem. It’s important to understand not only the hats that you wear but the hats that others are wearing as well.

THE WHITE HAT – the information hat – looking at what information is known and what is needed.

THE BLACK HAT – the judgment hat – playing devil’s advocate or thinking about why something might not work.

THE RED HAT – the emotional hat – it represents feelings, hunches, and intuition.

THE BLUE HAT – the thinking about thinking hat – used for managing the process, planning how to solve a problem and gain input.

THE YELLOW HAT – the optimistic hat – thinking about all of the reasons that something might work or what good might come out of a change.

THE GREEN HAT – the creative hat – focusing on the possibilities, alternatives, and new ideas.

Using each hat to think through a problem or situation will help you gain a well-rounded approach to an optimal solution. Think about thinking! For more information, visit www.debonogroup.com.

Mentor Program:
The AAP offers a formal Mentor Program to link new Administrative Directors with more experienced Admin Directors, to share knowledge, experience, skills and perspectives. More details on the office mentor Program, guidelines, and an online application can be found on the AAP Mentor Program website. Feel free to contact Amy Schnappinger at the AAP national office with any questions. However, also please feel welcome to also tap into the less formal process of mentorship and networking that is also available by using our listserv. This was one of the primary purposes of establishing the Administrative Director’s Council - for cross collaboration, open communication, sharing of ideas, Q&A on timely issues, etc. between ourselves. Any of the AD’s listed below are eager and committed to answering any questions or having you shadow them in their daily routine.

- Matthew Huish, MBA
  matthew.huish@hsc.utah.edu
- Geoffrey Hall, MBA
  geoffrey.hall@nyumc.org
- Monica Tietzworth, MBA, CMPE
  tietzworthml@upmc.edu
- Kirk Roden, MBA, FACHE
  Kirk.S.Roden@uth.tmc.edu

Job Board:
We have created a very simple spreadsheet and posted it on the ADC’s web-page for anyone that is aware of a PM&R Administrative Director “open position” can list it. This is supposed to serve as a value add to your AAP membership, by being made aware of other positions across the country that you can apply for upon your interest. Sign of an early or “inside scoop” on available positions. Please support this initiative by posting your position if you know you are retiring or vacating your position for any reason.

ADC Membership Survey:
There has been an expressed interest re-survey our ADC membership and post the results in an easily accessible location so that Admin Directors can then search other programs based on needs. So, if someone is interested in what PM&R Program has a functioning Cancer Rehab Program, or a Pediatric Inpatient Unit, or a certain sub-specialty Fellowship Program, etc., they could refer to the survey results and then reach out to the Admin Director of those programs. It would be a further way to pinpoint who to network with for any questions you have of your AD colleagues across the country.

The new survey is being sent to all ADC members via email, hopefully, the results will be shared during our business meeting at the Annual Conference.

Membership:
Sandy Wyn (WYNNS@ecu.edu) is Chair of our Marketing and Membership Committee and is working hard to recruit new members. If anyone is willing to assist in this challenging task, please reach out to Sandy who will be happy to share an assignment for talking to Admin Directors not currently in our AAP Administrative Director’s Council.
Feasibility of Using Mobile Health to Promote Self-Management in Spina Bifida

Facilitated By: Ami Mac, MD

AMI MAC: Could you tell me a little bit more about how this program came to fruition?

BRAD DICIANNIO: My interest in mobile health stems from seeing a lot of preventable conditions in our population that could be managed better if patients had more opportunities to enhance their self-management skills. And because our population is really tech-savvy, I saw this as a really good fit for this population to use mobile health as a way to intervene and possibly prevent some of these complications from occurring.

AM: How did you determine which features to add to the mobile app during its design?

BD: We based the design on some of the preventable conditions & topics that we saw as important places where we should intervene. We saw problems with urinary tract infections & pressure ulcers. So, two of the modules within the app itself target these chronic conditions. There’s an app that helps with bladder management. It provides reminders to do a daily bladder management regimen, which may include something like self-catheterization, and it provides a way for patients to report symptoms back to the clinician. Patients can report symptoms of a UTI, for example, early on, before it becomes a bigger problem. There’s also an app for skin breakdown and reminds patients to conduct a daily skin check to catch any problems early on. If they do find a problem, they’re able to report a wound, in terms of describing it to us and even sending us a picture.

AM: What would you recommend to others who would like to develop similar kinds of applications for other purposes?

BD: I think any type of application like this has to be very patient-centered. What was beneficial to us was that we spent a lot time with patients, asking them what they wanted and accommodating their needs above all else.

AM: What does the future hold for your app?

BD: For our app in particular, we have a lot of new features that we’re rolling out, including educational materials on their medical problems, a personal health record, and a gamifications feature for kids. We’re starting to enroll patients with spina bifida, spinal cord injury, and cerebral palsy. Cross-functionality on all smartphones is also a priority for us.

AM: You made mention of the spinal cord injury population; patients with cerebral palsy. Are there any other groups that you’re currently working with as well?

BD: We’re really interested in any disability that causes any type of problem with self-management, and where self-management efforts can improve outcomes. So, another example of patient population that comes to mind would be traumatic brain injury.

AM: Thank you so much for this insightful discussion on mobile health technology and spina bifida. We’re very excited to hear your talk, and more about this topic, at the 2016 AAP Annual Meeting.

This is a condensed version of an AAP Journal Podcast. Visit Physiatry.org/MP3 to listen to or download the complete interview. Visit Physiatry.org/AAP2016 to learn more about Brad Dicianno’s presentation at the 2016 AAP Annual Meeting.
AAP is proud to announce that we are changing our quarterly newsletter name from AAP NEWS to Physiatry Forward.

The newsletter has undergone a significant transformation in the past few years and contains new content aimed to move the field of Physiatry forward. Past newsletters are available for anyone to view on the AAP website – Physiatry.org/NewsletterAAP.

AAP would like to take this opportunity to thank you for your continued support. We look forward to delivering you quality material with a fresh new name.

Want to become an advertiser? Contact Leigh Patrick (lpatrick@physiatry.org) for more information on how to advertise in the new and improved Physiatry Forward.