High quality, credible feedback is necessary to provide a meaningful mechanism through which physicians can grow\(^1\) and provide better care. \textit{Feedback is fundamental in everything we do} — it is an essential part of every framework, every curriculum, every teaching interaction. There is evidence across specialties and professional roles that development of feedback-giving skills may allow us to take another step towards improving physicians' performance, and ultimately better patient care.\(^2\) Yet, both residents and faculty receiving feedback feel that the messengers are often not ready for the challenge that may be presented by real-life conversations. They are also not easily fooled by substandard feedback.\(^3,4,5\)

Meaningful and impactful feedback conversations are not easy. On one hand, our tensions impact the feedback process: balancing positive and negative feedback, our own perceived self-efficacy, our perceptions of the resident's insight, receptivity, skill and potential, our relationship with the resident and contextual factors.\(^6\) On the other hand, faculty from both university-based and community-based programs describe having minimal training and a lack of understanding of the best practices for delivering feedback,\(^6\) despite the availability of excellent practical guides.\(^7,8\) This does not appear to just be a perception issue — a recent qualitative study of simulated feedback encounters suggested that faculty skills do not match recommended practices.\(^9\)

So, what faculty behaviors make feedback meaningful and impactful?

Combining local pilot findings (unpublished) with the results of a focused literature review, let's look at one of my proposed dimensions — specificity — in greater detail.

We can think about specificity of feedback in two ways. One is quite literal — when giving feedback, use concrete patient encounters, behaviors and specific examples. This will enhance credibility of what you are saying, and will more likely be ‘accepted’ by the resident and hopefully lead to a positive behavior change. Residents very clearly reject feedback along the lines of "you are doing a great job" or "you should read more," no matter how true these statements may be.\(^4\) You can easily turn these into statements that are more likely to be used, such as "I really liked how you connected with the last patient, and how it made
Discussion of the treatment plan easier, “you should read about indications for different lower extremity orthoses because, during rounds, you struggled with deciding which brace would be most appropriate.”

The second way to look at specificity is a bit more complicated. In a nutshell, it has to do with matching the message to the recipient’s state of mind. Lefroy and colleagues(7) talk about tailoring bespoke feedback to the individual trainee. Some residents will benefit from reinforcement of key points done well, some from examples which might have been done better, some from a bit of handholding in working out strategies for improving the quality of their work, and some from help with increased self-awareness.

An “educational alliance” of faculty and residents has been compared with a therapeutic alliance, where a feedback conversation is likened to a relationship between a therapist and a client. One of the first steps necessary for an effective therapeutic alliance is establishing an accurate diagnosis, which we all do with patients in the course of our clinical work.

“Wait,” you say. “Despite often being called that word, we are not, in fact, psychiatrists. How do we ‘diagnose’ residents, and figure out what kind of feedback they need.” at that particular time in their professional development?” Despair not.

In our pilot study, faculty figured out that different strokes were indeed needed for different folks — the ‘cocks’ resident needed confronting, the ‘defensive’ resident needed specific examples and the ‘self-effacing’ resident needed resident exploration and support. I’m sure you’ve met these residents many times and can easily recognize them.

Roze des Ordons and colleagues(11) recently took it a step further. They not only explored the challenges that faculty experienced, but also suggested specific approaches that can be taken in adapting feedback conversations to individual residents. Their faculty were also able to adapt their approach to feedback, drawing on techniques of coaching for highly-performing residents, directing for residents with insight gaps, mediation with overly confident residents and mentoring with emotionally-distressed residents (Figure 1).

It may take a bit of practice, but trust that if your feedback comes from a position of beneficence, you will make an impact.

By: Alex Moroz, MD, MHPE, Vice Chair of the AAP’s Residency & Fellowship Program Directors Council (RFPD)

References:

FIGURE 1

FEATURE

TAKE AWAY POINTS FOR A BUSY CLINICIAN:

Early in the feedback conversation, decide if the resident falls into one of these common challenges.
- IF highly performing, THEN coach.
- IF insight gaps, THEN direct.
- IF overly confident, THEN mediate.
- IF emotionally distressed, THEN mentor and support.
- IF they don’t seem to fall into any of the above, THEN don’t stress. Just make sure to be specific and provide concrete examples.

Highly performing resident:
- Has good communication skills
- Seeks to understand patient’s goals
- Is able to appraise own communication skills realistically
- Seeks to improve further
- Insightful in discussions with the preceptor
- Interested in learning

Suggested approach:
- Frame feedback as a conversation and coaching to excellence
- Reinforce good performance
- Calibrate self-awareness and self-assessment
- Encourage resident to identify strengths and challenges, describe specific behaviors and their effects

Resident with insight gaps:
- Has an optimistic outlook, a positive attitude, and a cheerful approach
- Clearly lacking some core knowledge/skills
- Wants to impress you and is agreeable with any

Suggested approach:
- Recognize that repeatedly reiterating self-assessment questions is ineffective in eliciting gaps or achieving insight
- Adapt a directive approach to feedback

Emotionally distressed resident:
- Struggling with personal issues
- Difficulty focusing on clinical task
- Upset by suboptimal care and the personal issues
- Overwhelmed
- Difficulty listening

Suggested approach:
- Recognize distress—follow intuition
- Explore source of distress
- Normalize without minimizing
- Ask permission to defer feedback
- Refer up (PD, institutional support)
- Share own strategies

Overly confident resident:
- Has good communication skills
- Seeks to understand patient’s goals
- Is able to appraise own strengths and challenges, describe self-assessment
- Encourage reflection on patient experience
- Elicit resident ideas for implementing teaching points

Suggested approach:
- Frame feedback as a conversation and coaching to excellence
- Reinforce good performance
- Calibrate self-awareness and self-assessment
- Encourage resident to identify strengths and challenges, describe specific behaviors and their effects

Suggested approach:
- Ensure that your feedback comes from a position of beneficence, you will make an impact.

By: Alex Moroz, MD, MHPE, Vice Chair of the AAP’s Residency & Fellowship Program Directors Council (RFPD)
Dear Colleagues,

In my summer message, I introduced Daniel Goleman’s article, “Leadership that gets results” (Harvard Business Review, March-April, 2000) as an important contributor to my personal development as a leader. The article reviews six leadership styles and their relative contributions to the work environment and success of an organization. I reviewed two of these leadership styles that were most congruent with my personal disposition, “authoritative (visionary)” and “mentoring (coaching).” However, the article also introduced a critical concept: “Leaders need many styles.” That is, if we are to be effective leaders, we need to master four or more styles and understand when and how to invoke them. For this quarter’s Message from the President, I present two contrasting leadership styles, “affiliative” and “coercive.”

As with the “mentoring” style, the “affiliative” leadership style resonates with most physiatrists. After all, physiatrists are nice people! Also known as “servant leadership,” the mantra of the affiliative leadership style is “people first.” An affiliative leader praises and nurtures members to cultivate a sense of belonging to the organization and is associated with strong emotional bonds that engender loyalty. There is a strong sense of a “higher calling” with emphasis on the good of society and special appreciation for the marginalized and the disadvantaged. This style is especially effective where trust or morale needs to be improved. However, the exclusive use of this style can also create a culture of poor performance. Constructive criticism is often left out, which can lead to a culture of mediocrity and stagnation of workplace performance. Nevertheless, Goleman contends that the combination of “affiliative” and “authoritative” leadership styles is most effective in enhancing organizational performance.

The style that creates the greatest dissonance, especially among physiatrists, is the “coercive” leadership style. This style requires immediate compliance from employees, and its mantra is “do as I tell you.” People feel devalued, and, in most cases, this style inhibits the organization’s flexibility and innovation and dampens employees’ motivation and pride. Historically, this approach has unfortunately been prevalent in the training environment of academic medicine. The “coercive” approach is the least effective style among the six in Goleman’s article, and has a significant negative impact on the overall organizational climate. Nevertheless, this approach may be necessary and effective in turnaround situations, urgent circumstances (e.g., a natural disaster) or when working with problem employees.

As academic physiatrists, we naturally gravitate toward the “affiliative” leadership style and away from the “coercive.” We are fortunate that a physiatrist’s disposition aligns well with Goleman’s data. However, as leaders in academic physiatry, we must also be diligent to avoid taking the path of least resistance when a more challenging and less natural approach is required. Constructive criticism is essential if our learners, colleagues and field are to advance to the next level of clinical and academic excellence. Leaders, at times, need to make unpopular decisions in the best interest of the department, the organization and society. We need to exhibit courage to make such decisions, especially when it may not be in the best interest of an individual or a group. Finally, we will always face challenging students, residents, fellows and faculty. Performance improvement plans are difficult to implement and, at times, termination is the best or the only option available. Perhaps the most challenging application of Goleman’s article is not determining your own leadership style as academic physiatrists, but understanding the styles that are outside of your comfort zone and learning when and how to apply them for maximum effectiveness.

Sincerely,

John Chae, MD, ME
President of the Board, Association of Academic Physiatrists
The Association of Academic Physiatrists is dedicated to developing the careers of future academic physiatrists and this mission extends to its journal, the American Journal of Physical Medicine & Rehabilitation (AJPM&R). Many PM&R trainees have limited exposure to the peer-review publication process, which can be intimidating without appropriate guidance and mentorship. As a result, early career physiatrists may avoid pursuing the rigorous research that is needed in physiatry to advance our field and ensure appropriate, evidence-based medical practice, and may also deter trainees from considering an academic career.

AJPM&R Editor-in-Chief, Dr. Walter Frontera, has created the “Resident and Fellow Section,” a new section of the journal with published articles authored by trainees in physiatry covering topics relevant to our training. Dr. Dinesh Kumbhare will serve as the Associate Editor of the section, and five in-training physiatrists have been selected to serve as Section Editors through a national application process. The goals of the Residents and Fellows Section are to introduce trainees to the peer-review process, provide additional educational resources for trainees as well as practicing physiatrists, encourage critical reading of primary literature and lead residents and fellows to consider pursuing original research studies in the future.

We encourage all trainees, including medical students, residents and fellows, to submit articles to the Resident and Fellow Section. Articles should be prepared by trainees as the primary author(s) under the supervision of an attending physician. The focus of this section is to provide material relevant to PM&R training. Submitted articles will undergo a rigorous peer-review process led by the Resident and Fellow Section Editors prior to publication in AJPM&R.

**YOU CAN EXPECT TO SEE THE FOLLOWING CATEGORIES OF ARTICLES:**

1. A blog maintained by the Resident and Fellow Section Editors highlighting important recent research relevant to the clinical practice of physiatry.
2. Education and training articles describing new resident-led educational programs or quality improvement initiatives to improve the education of trainees or increase exposure of medical students to the field of physiatry.
3. Clinical vignettes leading readers step-by-step through interesting clinical cases designed to enhance clinical reasoning skills and increase knowledge of important diagnoses and management approaches within the field of physiatry.
4. Teaching images or videos that demonstrate examples of observations, techniques or findings important for trainees.
5. Clinical pearls that consist of short cases covering board-relevant topics encountered by physiatrists. These articles will also provide additional references for the reader to obtain more in-depth knowledge of the material.

Please visit the AJPM&R website at [www.ajpmr.com](http://www.ajpmr.com) for additional information (including guidelines for authors), or contact Dr. Kumbhare at Dinesh.Kumbhare@uhn.ca with any questions.

We are excited to begin receiving your submissions and look forward to building this unique platform to further enhance PM&R education!
On April 13 and 14, 2018, Memorial Sloan Kettering Cancer Center (MSKCC) held their 2018 Cancer Rehabilitation Symposium, titled “A Collaborative Approach to Enhance Quality of Life.” Leaders in the field were invited to share their evidence-based research and experience on addressing the rehabilitative needs of patients with adult and pediatric cancers.

Over 150 people attended the symposium, visiting Manhattan from 16 states and 5 countries. The audience was comprised of physicians, physical therapists, occupational therapists, speech language pathologists, physical and occupational therapy assistants, nurses, nurse practitioners, cancer center administrators, healthcare students, social workers, case managers, psychologists and other healthcare professionals interested in cancer rehabilitation.

Keynote speaker, Dr. Julie Silver, Director of Cancer Rehabilitation at Spaulding Rehabilitation Hospital/ Harvard Medical School outlined Rehabilitation Opportunities in Oncology. Plenary speakers included MSKCC faculty Drs. Christian Custodio, Theresa Gillis, Lisa Ruppert, Katarzyna Ibanez, and Jonas Sokolof; highlighted by an interactive “Meet the Experts” Q&A panel, which the audience found particularly engaging. Kessler Institute for Rehabilitation’s Dr. Ashish Khanna shared, “I really enjoyed the 15-minute format for the series of talks. This condensed synopsis allowed speakers to discuss their areas of expertise adequately, while continuing to hold the listeners’ attention. It also allowed time to really reach a breadth of topics in cancer rehabilitation.”

The second day of this two-day symposium included a poster awards presentation, breakout sessions, as well as workshops on ultrasound, bracing and botulinum toxin injection techniques. “The symposium was a great way to not only learn about various cancer rehab topics, but also to meet PTs, OTs, SLPs, nurses and physiatrists from across the country with enthusiasm for this growing field,” remarked Dr. Katherine Power, MedStar NRH Cancer Rehabilitation Fellow.

Here were some key takeaways:

- Cancer rehabilitation focuses on improving survivors’ functional status. Impairments may be secondary to cancer-related symptoms or treatment side effects.
- Early integration of cancer rehabilitation in oncology care is recommended to preserve and/or optimize quality of life.
- MSKCC plans to host another Cancer Rehabilitation Symposium in 2020.
Become a LEADING REHABILITATION RESEARCHER

Apply for the Rehabilitation Medicine Scientist Training Program (RMSTP)

Successful research is essential to building strong PM&R departments, raising the visibility of rehabilitation and advancing medical science. That’s why the AAP offers RMSTP, a program that is cultivating today’s top physician-researchers in physiatry.

Through multidisciplinary mentoring, networking and workshops, you will learn how to compete successfully for NIH and other research funds, as well as contribute original research to the specialty.

Learn more and apply by November 1, 2018 at www.physiatry.org/RMSTP.

Academic Faculty Position in Physical Medicine & Rehabilitation

The Department of Physical Medicine and Rehabilitation, University of Kentucky College of Medicine has an opening for a Clinical Title Series Position.

The successful applicant will have experience in the field of Physical Medicine and Rehabilitation with a focus on inpatient and outpatient General Rehabilitation. Responsibilities include providing both inpatient and outpatient physical medicine and rehabilitation services and clinical teaching of residents, fellows and medical students. Applicants must have an M.D. or D.O. degree, be board certified or board eligible in Physical Medicine and Rehabilitation and have demonstrated excellent qualifications in Clinical Care and Education.

Existing facilities include a 945-bed Level 1 trauma center, affiliation with Cardinal Hill Rehabilitation Hospital, a 158-bed free standing rehabilitation hospital, and NIH supported General Clinical Research Center. Salary and academic rank will be commensurate with qualifications and experience of the applicant.

For further information, please see our website at: https://pmr.med.uky.edu

PLEASE SUBMIT, VIA EMAIL, CURRICULUM VITAЕ AND THE NAMES AND CONTACT INFORMATION FOR THREE REFERENCES TO:

Susan McDowell, MD – Chairperson
susan.mcdowell@uky.edu
UK Physical Medicine and Rehabilitation, c/o Cardinal Hill Rehabilitation Hospital
2050 Versailles Road, Lexington, KY 40504

The University of Kentucky is an equal opportunity/Affirmative Action employer and complies with the Americans with Disabilities Act of 1990. Females, racial minorities, and individuals with disabilities are encouraged to apply. Upon offer of employment, successful applicants for certain positions must pass a pre-employment drug screen and undergo a national background check as required by University of Kentucky Human Resources.
MEDICAL LICENSURE – STATE RIGHTS VS. THE COMMON GOOD

By: Joel DeLisa, MD, MS, Editor of Physiatry Forward

Although Federal standards govern medical training and testing, each state has its own licensing board. The Federal government does not grant medical licenses and doctors must procure a license in every state in which they practice. However, a physician practicing in a Federal facility (Veteran’s Administration), Federal prison, U.S. Military and/or Indian Reservation (Indian Health Service) needs a licensure from any state, not just the one they are residing in. The basic standards for initial physician licensure are uniform: the applicant must show proof of graduating from an accredited medical school and completion of at least one year of an accredited residency training program, provide information concerning malpractice suits and pay a fee to the state. The physicians must pass either the United States Medical Licensure Examinations or the Comprehensive Osteopathic Medical Licensure Examination. In addition, some states require future testing, special course work, a criminal background check, a face-to-face interview, and/or proof of participation in other training programs or continuing medical education courses. When I applied for my medical license in New Jersey in 1987, I was required to submit a copy of my high school diploma. This is an archaic system that can best be described as “State Rights.” During emergencies, such as 9-11, Katrina, etc., individual state licensure requirements can have harmful consequences. In those states, any out-of-state private practitioner who renders voluntary aid must in effect practice medicine without a license, potentially placing themselves at risk for civil and/or criminal penalties. This can become more of an issue as telemedicine becomes more widespread across state lines and now this technology is becoming more widely used and is especially helpful in remote areas where physician coverage is often sparse. Telemedicine is an innovation which should benefit providers, patients, and payers, but the state licensure issue has stifled its growth. It also affects team physicians traveling to athletic competitions in other states.

Currently physician application fees for a license and timelines vary markedly by state. The application fee varies from $20 to $1,090. Background check fees are required by eight states and this varies from $20 to $60. However, a number of additional states accept the Federation Credentials Verification Service (FCVS), whose parent organization is the Federation of States Medical Board (FSMB). It is a fast and convenient way for a physician to store their credentials that can be used by multiple state medical boards as a primary source of verification. It includes a background check and fingerprint cards and the initial fee is $392.75. The average time for obtaining the state medical license from the state board after the required items have been submitted is two weeks in one state and up to six months in another.

FSMB has taken steps towards implementing a system of expedited endorsement, which offers qualifying doctors a simpler and more standardized licensure application process. It is called the Interstate Medical Licensure Compact (IMLC). However, the physician must pay the initial licensure fee in any and all states in which they desire to practice. Hence, while it makes the initial application process more streamlined, it still endorses the “State Rights” philosophy which preserves state authority over the practice of medicine as protected by the 10th amendment. About 17 states are currently participating to various degrees in the IMLC program. An option to improve licensure would be that states could go further by adopting mutual recognition agreements in which they honor each other’s license. Mutual recognition has been adopted in the European Union and Australia. In my opinion, a superior system would be a federal medical licensure that would be recognized in all states and territories. If this were to occur, the Federal government would have to develop a system for receiving, investigating and disciplining. The basic standards for physician training and testing are already applied nationally. The current system imposes significant costs on those who wish to practice medicine with little additional benefits to society. It is time that the “State Rights” argument is abandoned. However, since physicians value self-regulation, many may consider this an impingement on their professionalism. I suspect that only a legal challenge addressing this issue may need to go to the Supreme Court for a decision to change the current process.

References:
2. Sullivan, T. Interstate Medical Licensure Compact Expands to 17 States. May 5, 2018

BECOME THE NEXT EDITOR OF PHYSIATRY FORWARD!

Follow in the footsteps of Joel DeLisa, MD, MS, who has served as this publication’s editor since 2015. As editor, you will submit a 500-word editorial article to each publication focused on a topic relevant to academic physiatry. Physiatry Forward is published every January, April, July and October. We are seeking a two-year commitment from the new editor. Learn more and apply now at www.physiatry.org/Volunteer!
A Look at the World Spine Care Conference

By: Anthony Chiodo, MD, MBA

The AAP was pleased to sponsor the 3rd World Spine Care Conference, “Creating a country wide program for the prevention of spine disability,” in Gaborone, Botswana on May 7-8, 2018. The World Spine Care (WSC) is a non-profit organization with the goal of helping people with spinal disorders in underserved communities throughout the world. Their work revolves around educating local health professionals how to better diagnose, triage and manage spinal disorders in primary care settings, as well as training rural and tribal volunteers in identifying flags in spine care and basic yoga.

In support of this organization’s mission, the AAP provided a grant for travel to one of its members — and I was pleased to be the recipient. I presented on Health Maintenance in Spinal Cord Injury and on Musculoskeletal Disorders and Management in Spinal Cord Injury. These presentations were part of a program with Katarzyna Trok, MD and Inka Löfvenmark, RPT, PhD from the Spinalis Clinic in Sweden that included topics on bowel and bladder management, skin injury prevention and equipment adaptation in underserved countries.

Over 300 physicians, nurses, therapists and students attended this year’s conference. As shared by Dr. Scott Haldeman, President of WSC, “The support of the AAP and other associations who have endorsed the WSC programs allows WSC to offer the highest level of education to government employed health care providers without a registration fee. These clinicians have limited resources and fixed income. They provide care to the lowest income Botswana citizens which is consistent with the mission of WSC.”

TAKEAWAYS FROM THE OPDA SPRING MEETING

By: Vu Q. C. Nguyen, MD, the AAP’s OPDA Representative

The Organization of Program Director Associations (OPDA), a convened group of the Council of Medical Specialty Societies (CMSS), is dedicated to promoting the role of the residency program director and program director societies in achieving excellence in graduate medical education. Below are some of the topics discussed at our Spring meeting.

Association of American Medical Colleges (AAMC) Updates

The AAMC has developed an initiative called “Apply Smart” in which residency applicants can enter their USMLE Step 1 score and get a graphical depiction of the optimal number of applications that they should submit. This will data covers 19 U.S. medical specialties, not yet including PM&R. Learn more at www.aamc.org/applyingsmart.

The AAMC now offers a pamphlet titled “Best Practices for Conducting Residency Program Interviews” to help reduce variability in how applicants are interviewed across programs and specialties.

The Program Director’s Workstation (PDWS) is being redesigned to be more user friendly, and the AAMC will be asking Program Directors to submit their program information earlier for applicants. ERAS will not do background checks or verify applicants’ data.

National Resident Matching Program (NRMP) Updates

2019 is the final year of the American Osteopathic Association (AOA) Match. After that, osteopathic programs will either be ACGME-accredited or not, so start preparing now. In addition, NRMP reports for the Program Director Survey and Match Outcomes were released July 1st. You can find them at www.nrmp.org/main-residency-match-data.

Accreditation Council for Graduate Medical Education (ACGME) Update

The ACGME wants the OPDA to create a quality improvement workgroup that develops ways/processes to educate and develop faculty skills and knowledge in QI/PI. You would pay for your own travel to and stay in Chicago, but they will provide food and meeting space. If interested, contact ketolen@acgme.org.

National Board of Medical Examiners (NBME) Updates

The NBME has launched a task force called RENEW that aims to: 1) Assess medical student wellness and stress based on their United States Medical Licensing Examination (USMLE) outcomes; and 2) Assess the relationship between self-care and preparation for assessment exams by medical students. Representatives of various stakeholder groups are collaborating with NBME on data sharing and resource allocation for next steps. The NBME has also created a Resident Advisory Panel to create stronger relationships with examinees specific to the USMLE.

American Medical Association (AMA) Updates

The AMA is updating FREIDA to make it more user-friendly. There is also a new feature that allows residency and fellowship programs to post their vacancies, which you are encouraged to update throughout the year. Contact freida@ama-assn.org with any questions.

Finally, a push is underway for a uniformed start date of August 1st for fellowships to make the transition more streamlined for residents. International Medical Graduates (IMGs) have also requested a resolution that would allow foreign-trained physicians to bypass the U.S. residency training program by taking a competency exam.
ADMINISTRATIVE DIRECTORS CORNER

The Administrative Director’s Council (ADC) is putting together strong program again — designed by and for administrators — for Physiatry ’19, the AAP’s Annual Meeting in Puerto Rico. Some of the hot topics we’ll be discussing include:

• Health Care Reform
• Developing a Cancer Rehab Program
• Telehealth
• Mobile Research
• Employee Contracting

The ADC will also host a workshop on Wednesday, February 20, 2019 from 1:00pm to 5:00pm and a joint Chair/Administrator session on Friday, February 22, 2019 at 7:00am. You are welcome to join us!

We look forward to seeing all of the Administrative Directors at the 2019 meeting. If you are a new Administrator or have not yet joined the AAP, our ADC leadership is here to answer any questions. You can reach out to Kirk Roden, ADC Chair (kirk.s.roden@uth.tmc.edu), or Monica Tietsworth, ADC Chair-Elect (monica.tietsworth@nyumc.org). Thank you and we’ll see you in Puerto Rico!

PROGRAM COORDINATORS CORNER

The Program Coordinators Council (PCC) is thrilled to share our schedule for Physiatry ’19! Plan to arrive on Tuesday, February 19, 2019 for a joint workshop with Program Directors and get ready for a jam-packed schedule that will help you be more effective in your role. Check out the Preliminary Program (which you should have received in the mail) or visit www.physiatry.org/2019 for the full schedule.

Proposed New Common Program Requirements – Effective July 1, 2019
The proposed New Common Program Requirements (CPRs) for Sections I – V are under review. Start planning to implement them in your program now in the event that they are approved. Please note that the proposed new CPRs are separate for Residency and Fellowship. Summation for Section II-III is provided below. You’ll find summations for Sections IV and V in the Winter issue of Physiatry Forward. These summaries were done by Wendy Helkowski, MD, Program Director at UPMC.

SECTION II
Program Director
• 3 years experience
• Core programs: Minimum 20% (8 hours/week) salary support (may be further specified by RC)
• ABMS or AOA certification acceptable
• Must have ongoing clinical responsibilities
• Must have authority to appoint and remove faculty and remove residents from substandard experiences
• Role model of professionalism
• Resident/fellow non-compete prohibited
• Provide requested verifications within 30 days of program completion

Faculty
• Annual faculty development activities (teaching, PS/QI, well being, patient care)
• AOA or ABMS certification accepted

Core Faculty
• Based on role in program, not on number of hours (at minimum PEC and CCC members)
• Scholarly activity assessed as a whole, not individually

Program Coordinator
• Support must be at least 50% for core programs (20 hours/week)
• Fellowship requirements do not specify minimum level of support (RCs may specify)

SECTION III
Resident Appointment
• Eligibility:
  o Core programs: ACGME-I acceptable pre-requisite training
  o Fellowship review committees choose:
    - Option 1: ACGME or AOA
    - Option 2: ACGME, AOA, RCPSC, CFPC or ACGME-I
• Resident transfers: competency-based performance evaluation before acceptance and milestones performance before matriculation

Please plan to join your fellow coordinators for a stimulating and fun experience at Physiatry ’19 in Puerto Rico. Contact Cindy Volack with ANY ideas and/or to sign up to present.

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The American Medical Association (AMA) held its House of Delegates (HOD) Annual Meeting in Chicago, IL from June 9-12, 2018. The AAP was represented by Samuel Chu, MD of the Shirley Ryan AbilityLab as a member of the Specialty and Service Society (SSS), which is made up of more than 130 national medical societies, military services and professional interest medical associations. The AMA HOD, comprised of physicians from across the country who represent state or specialty societies, meets twice a year to review and discuss hundreds of resolutions related to issues on health and medicine.

Several AAP committees and councils were instrumental in reviewing and providing feedback on various resolutions and reports prior to the meeting, and their assistance is much appreciated. Here are some policy highlights discussed at the AMA HOD Annual Meeting:

PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDD) DESIGNATED AS A MEDICALLY UNDERSERVED POPULATION

This resolution, introduced by the AAPM&R delegation, asked that the AMA advocate for persons with IDD to be included as a medically underserved population and encourage medical education on related objectives and competencies. There was strong support for this resolution, noting that individuals with IDD represent a high-risk population that may require additional health resources. The HOD adopted this resolution and also reaffirmed existing AMA policy on this matter.

ADVANCING GENDER EQUITY IN MEDICINE

A number of resolutions were introduced regarding gender equity and disparity in the medical profession. Dr. Julie Silver helped co-author several of the resolutions on gender equity and compensation. There was strong support and recognition of problems with gender disparities in medicine. The HOD ultimately adopted a combined resolution in support of reducing gender bias in medicine and creating a report detailing the AMA’s position and recommendations on this issue by 2019.

OPIOID EDUCATION

There was strong support for this resolution that asked the AMA to work in conjunction with the ACGME to establish opioid education guidelines for in-training physicians, medical students and practicing physicians.

WHY SHOULD YOU JOIN THE AMA?

In order for the AAP to be a member and participate in the AMA, the AAP must maintain a certain number of AMA members. It is important for the AAP to have a voice! Please consider joining the AMA so that the AAP can continue to represent you and the field of physiatry. For more information on AMA membership, visit www.ama-assn.org/membership.
CONGRESS RETURNS IN SEPTEMBER WITH HOPES OF FINALIZING ITEMS BEFORE ELECTIONS

The House returned to Washington after Labor Day to resume legislative work following the traditional August recess, while the Senate spent much of August in session as priority issues continue to pile up. With the Congressional calendar in the 115th Congress ending September 30th, lawmakers are feeling the pressure of legislating in an election year.

Topping the list of Congressional priorities is appropriations as Congress has yet to pass any of the 12 spending bills needed to fund the government in Fiscal Year 2019 (which begins October 1st). Lawmakers will have to focus on appropriations if they want to avoid having to fund the government with short-term funding packages. The most contentious of the bills, the Labor/HHS/Ed spending bill, has passed both the House and Senate in different versions and they are now waiting to pass the conference agreement before sending that spending measure to the President. That conference agreement currently funds the Departments of Labor/ HHS/Ed at about $178.1 billion, roughly $1 billion more than the House has originally passed. The big winner of that increase would be the National Institutes of Health (NIH), which would get a $2 billion increase, or an increase of 5.4%. Congress is expected to pass the measure before the October 1st deadline.

A recently released Statement of Administration Policy expressed disappointment that the Labor/HHS/Ed bills currently working their way through Congress don’t consolidate HHS research programs on health care, occupational safety and disability into the NIH as the President had proposed in his Fiscal Year 2019 budget. The AAP has opposed the consolidation of the disability programs, which suggested the consolidation of three health research agencies and offices in the Department of Health and Human Services into NIH: the Agency for Healthcare Research and Quality; National Institute on Occupational Safety and Health; and National Institute on Disability, Independent Living and Rehabilitation Research. The plan asserts the merger and creation of the three new NIH institutes will “improve research coordination and outcomes.” To date, lawmakers have rejected the White House’s research consolidation proposals.

In addition to appropriations, the Senate is expected to spend a large amount of time considering President Trump’s nomination of Brett Kavanaugh to the Supreme Court, whose confirmation hearings began on September 4th. The Senate has also made passing an opioid abuse package a priority. The Senate currently has four committees working to craft opioid packages, which are currently awaiting votes on the Senate floor. Those bills then need to be resolved with differences from the House-passed opioid legislation (HR 6) from earlier in the year. At this point, it’s unclear if the Senate would take action on opioids before the midterm elections. Both the House and Senate are scheduled to break for the mid-term elections around mid-October.
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