The International Classification of Functioning, Disability and Health, better known as the ICF, is one of the classifications of the World Health Organization’s Family of International Classifications (WHO-FIC). The World Health Organization (WHO) is the United Nations’ directing and coordinating authority on international health. The purpose of the WHO classifications is to provide a consensual, meaningful and useful framework that all stakeholders can use as a common language. Along those lines, the WHO-FIC has developed classification designed to provide the basic details of health. The most well-known, the International Classification of Disease (ICD-10), is the standard diagnostic tool for clinical purposes. A second classification, the International Classification of Functioning, Disability and Health (ICF), measures health and disability through identifying levels of functioning.

The ICF uses the concepts of functioning, disability and health. Functioning refers to what a person does or can do; disability to what a person does not or cannot do. These descriptors of functioning become indicators of health and health-related states. A core principle of the ICF is that functioning is universal to all persons. The ICF emphasizes the positive rather than negative aspects of functioning. It provides complementary information to that from the ICD-10 and is independent of specific health conditions.

The ICF provides a bio-psycho-social framework for organizing functioning and disability. Both biologic factors including psychological elements and environmental factors, including social roles, influence the levels of functioning and disability. Environmental factors may be most influential in determining disability, i.e. to what extent individuals may participate in life activities.

The ICF can be viewed as having three levels. The first is a conceptual framework for the organization of the components of functioning. Its components are: (1) body functions: physiological and psychological functions of the body systems; (2) body structures: anatomic structures of the body; (3) activity: the capacity to perform an activity; and (4) participation: the performance of activities in real life. Additional conceptual components are called contextual factors and include (1) environmental factors and (2) personal factors. Although the ICF identifies personal factors as a component, it has not developed codes for it.

A core principle of the ICF is that functioning is universal to all persons.

The ICF emphasizes the positive rather than negative aspects of functioning.
This diagram illustrates the conceptual components of the ICF and their interrelationships. The arrows show how they interact with each other in both directions and in a non-linear fashion. The level of participation can vary from changes in the environmental factors and/or personal factors even when there are no changes in activity.

The second level of the ICF includes a complete list of possible functioning categories. The list includes (1) 493 categories of body functions, (2) 310 categories of body structures, (3) 384 categories of activities/participation, (4) 253 categories of environmental factors and (5) 0 categories of personal factors.

At its third level, the ICF includes the capacity to report the quantified level of functioning of each of the categories. The ICF refers to these as qualifiers. They provide a reporting framework that quantifies functioning using a five-point scale. Appropriate psychometric analysis can translate the scores of virtually any instrument measuring function into the five-point scale. Monitoring clinical courses requires being able to measure functioning at different points in time.

**ICD-11.** The WHO is in the process of developing ICD-11, which is due for release in 2018. A new feature of the ICD-11 is Section V: Supplemental section for functioning assessment. This section is composed of 17 subsections derived from the Body Functions and Activity/Participation components of the ICF. This will create the option for coders of ICD-11 to include information on functioning. The specifics on how this will be implemented, particularly in the United States, are uncertain at present. Some see this as a way of bridging from limited coding of functioning in the ICD-11 to more complete coding of functioning through the ICF.

**U.S. Physiatrists and the Current ICF.** U.S. physiatrists are likely to have contacts with the ICF in several ways: (1) Much of the published literature uses the language and concepts of the ICF. This is especially true of international papers; (2) Several centers in the U.S. are collecting outcome information using ICF compatible assessment instruments; (3) CARF criteria reflect ICF concepts and frameworks; (4) Presentations regarding outcomes as quality indicators often will use the ICF as their framework.

**Physiatric Advocacy and the ICF.** Databases reporting the functional status of patients include information important to physiatrists. They emphasize the role of the physiatrist and provide outcome measures of their successes. Physiatrists should support efforts to measure outcomes through functional information. The data becomes even more useful if they can be compared widely among practices, health systems, nationally or even internationally. Expanding the use of an already implemented classification such as the ICF would facilitate these wider comparisons. Physiatrists should become advocates for expanding the use of the ICF and of the functioning codes of the developing ICD-11.

References:
2. About WHO. Accessed 05/24/18 at http://www.who.int/about-us

By: Joel DeLisa, MD, MS, Editor of Physiatry Forward
John Melvin, MD, MMSc
Dear Colleagues,

As I enter the latter half of my term as President of your Association, I am pleased to devote the final three editions of the Message from the President on leadership. For nearly 20 years of my career, my contribution to the field of physiatry was primarily as a physician-scientist. Then in 2013 I was appointed Chair of PM&R at the MetroHealth System and Case Western Reserve University. In 2015, I was appointed Medical Director of the Neuromusculoskeletal Service Line where I led the clinical operations of the departments of Neurology, Neurosurgery, Orthopedics, Pain-anesthesia and PM&R. In 2017, I was promoted to Vice President for Research and Sponsored Programs for my health system. I continue to serve as Chair of PM&R and maintain this dual leadership role today. And, of course, I have served on the Executive Committee of the AAP since 2013 and as President since 2017. During this whirlwind 5-year tour of leadership opportunities, I've learned many things, but mostly through mistakes and challenges.

I credit many for helping me to develop as a leader, including my superiors, mentors, colleagues and the people that I've led or trained. However, another important resource that has helped me greatly in this journey is Daniel Goleman's landmark article, “Leadership that gets results” (Harvard Business Review, March-April, 2000). Goleman makes the case, with empirical data, on the importance of understanding and strategically implementing six leadership styles to be an effective leader: coercive, authoritative, affiliative, democratic, coaching and pacesetting.

The natural tendency for all of us is to gravitate toward the leadership style that is most consistent with our personal disposition. I tend to gravitate toward “authoritative” and “coaching.” Consistent with “authoritative” leadership, I am strongly motivated by a clear vision that advances the good of the collective and seek to impart that vision on others, but leave the “how” to the team. According to Goleman, this style has the most positive impact on change and its strength is enthusiastic, long-term direction. However, this style does not work well when the leader is working with a team of experts or peers who are equally or more experienced or when the leader is so far ahead that the team can’t differentiate the leader from enemy. In these situations, an “authoritative” leader can come across pompous or out of reach.

Contrary to the traditional boss approach, the “coaching” style, also known as the “mentoring” style, focuses on the strengths and weaknesses of a trainee or employee in order to improve and encourage. The implicit message is “I believe in you, I’m investing in you, and I expect your best efforts.” As clinicians and scientists, mentoring is a way of life and perhaps the style we feel most comfortable with and, therefore, the style we most often gravitate toward. However, this style is time-consuming and the outcome is focused more toward personal development rather than the efficient and effective completion of tasks. This style also requires competency of the coach and is ineffective if the trainees are resistant to learning or changing their ways.

While I gravitate toward these two leadership styles, the most critical concept I learned from this article is that “Leaders Need Many Styles.” If we are to be effective leaders we need to master four or more styles and understand when to invoke them. This can be difficult, if not intimidating, because this requires that we leave our personal comfort zone and get beyond “my disposition” in order to achieve this. Thus, I, too, had to understand and learn when and how to implement the other four leadership styles: coercive, affiliative, democratic and pacesetter. Therefore, I will devote my last two Messages from the President on these four leadership styles.

Sincerely,

John Chae, MD, ME
President of the Board, Association of Academic Physiatrists
Why Nepal and what is your current setting?

GROVES: While considering international locations, I was primarily interested in low- and middle-income countries where I could focus within the scope of PM&R. Not only did Nepal fit that profile, but there are other colleagues here from IU (in different disciplines), so it was a great option. I work at the Spinal Injury Rehabilitation Centre, Nepal’s largest SCI rehabilitation hospital. We recently started providing stroke rehabilitation, as well. We typically have 60 individuals with new SCI on our inpatient wards and 5-10 individuals with new stroke. It’s a privilege to be here working alongside Dr. Raju Dhakal, Nepal’s first (and currently only) residency-trained physiatrist practicing in the country. I help provide clinical education for our medical staff and support clinical research at the centre.

How does your practice in Nepal compare to that of the U.S.?

GROVES: In both positive and negative ways, resources are the most obvious difference. Here in Nepal, the strongest resource by far is the family unit. Every patient is accompanied by at least one family member (if not many!) around the clock, and we rarely have to worry about an individual having adequate support at home. It’s truly remarkable and admirable. Additionally, the resilience and ingenuity of our staff is profound. They aren’t discouraged by the limitations of our context. On the contrary, they continually find ways to do great work with few resources.

Thankfully, a lot of what we do in PM&R is hands-on and people-dependent, rather than technology-dependent. We don’t use many different treatments from that of U.S. practitioners, but we certainly use resources differently. Catheters for clean intermittent catheterization, for example, are often reused for one month. Also, as we pursue spasticity treatment options, we’re focusing on phenol rather than botulinum toxin because its more economical.

The lack of medical treatment options in Nepal is substantial. Long-term ventilation support for individuals with tetraplegia is not an option. Things like botulinum toxin and phenol are not available for treatment of spasticity. Medication for DVT prophylaxis, as just one example, is cost-prohibitive for most of our patients. Staffing an interdisciplinary team is also challenging, as opportunities don’t exist in Nepal for PM&R specialty training or occupational therapy training. We have geographical limitations, as well. Patients come from all over the country for acute rehabilitation, but many return home to places that are hours, if not days of travel from the hospital. This makes any kind of medical follow-up very difficult and for many, impossible.

Is there anything our members can do to support developing countries in establishing strong PM&R presence?

GROVES: I’ve been encouraged by the AAP’s newly developed Presidential Task Force to Advance Global Academic Physiatry, and I know that many of our members already support providers in developing countries in significant ways. Seeking opportunities to provide ongoing mentorship and sponsorship for clinicians in low- and middle-income countries are other great ways to get involved. Certainly, if any members are interested in a long-term partnership with us here in Nepal, they’re welcome to get in touch with me at ccgroves@iupui.edu.
SUBMIT YOUR ABSTRACTS FOR PRESENTATION!

Share your cutting-edge work and advance the field of physiatry. Your research and/or case report may be showcased at our lively Poster Gallery receptions, in the American Journal of Physical Medicine & Rehabilitation, or even in the news!

CALL FOR ABSTRACTS CLOSES SEPTEMBER 7TH
SUBMIT NOW AT WWW.PHYSIATRY.ORG/ABSTRACTS2019

INTRODUCING OUR NEW VIRTUAL CAMPUS
Visit campus.physiatry.org for your CME and MOC needs!

From webinars and leadership modules to podcasts and AJPM&R activities, the AAP has created a new Virtual Campus to help you stay on top of your career and the ever-evolving field of physiatry.

Get Started with the AAP-UPMC Research Mentorship Series

Through a partnership with UPMC (University of Pittsburgh Medical Center), you now have the key elements of successful research at your fingertips. Topics include critical literature review, finding mentors and funding, choosing methodology, and selecting a journal. Best yet, it’s all free!

Get your institution in front of leaders in physiatry by sponsoring a webinar. Contact brensing@physiatry.org or 410-654-1000 to learn more.

Find all of this and more at campus.physiatry.org!
MENTORSHIP

RESEARCH ADVICE FOR IN-TRAINING PHYSIATRISTS

By: Allison Schroeder, MD, Research Representative of the AAP’s Resident/Fellow Council (RFC)

The Rehabilitation Medicine Scientist Training Program (RMSTP) was first funded in 1995 to train clinician scientists to improve research capacity and advance the field of physiatry. John Whyte, MD, PhD, Director of Moss Rehabilitation Research Institute, was instrumental in its inception and was kind enough to answer a few questions about the program. This interview serves to both highlight research growth opportunities and garner advice that can be applied beyond the research realm.

Q. What do you feel has been the biggest success of the RMSTP program?

DR. WHYTE: When I entered the field, I felt I was pretty unusual in having a scientific or theoretical orientation toward my work. Most colleagues learned from clinical mentors to do what was done before. I now feel surrounded by serious scientists in PM&R and I feel like the entire level of discourse is more rigorous and scientifically sophisticated. I believe that the critical mass of RMSTP trainees themselves, and the effect they’ve had on their colleagues and trainees has been a major factor in that transformation.

Q. Do you have any advice for maintaining work-life balance as a physician, and especially as a clinician-scientist?

DR. WHYTE: For starters, if you are able to be reasonably successful in research, then the work, though very demanding and time-consuming, is also largely under your own control. Yes, I may need to work some weekends. But I decide when to do that because I decide what grants I want to apply for. I work many hours but my work is self-directed and I like to tell people that I can do pretty much anything I want to if I can raise the money to do so.

Q. What final advice do you have for residents or young attendings when incorporating research in their career?

DR. WHYTE: One of the most challenging things is the increasing split between clinicians and researchers. Science has become more complex, technical, and team-oriented, such that one typically has to spend more time immersed in it to remain competitive. At the same time, clinical departments have less financial surplus with which to fund research. So much of a middle ground for those who would like to be active in both worlds. Those who want a major component of research in their professional lives would be wise to seek some advanced training so that they can be competitive at getting grants to fund their creative research ideas.

Whether you pursue a research or clinical career, your work will be influenced by the discoveries of clinician-scientists, many of whom have been a part of the RMSTP. Thank you to Dr. Whyte for providing his perspective and advice. For more information on the RMSTP (and to get involved), please visit www.physiatry.org/RMSTP. Applications open in October!
Well-being is defined as a state characterized by health, happiness, and prosperity. Alternatively, burnout is defined as emotional exhaustion, depersonalization, and sense of low personal accomplishment. Physicians have traditionally been charged with maintaining the well-being of their community. However, recent literature has shown that physicians, both at the attending level as well as those in residency programs, report alarming rates of burnout and depression. Resident surveys show poor dietary habits, inadequate sleep and exercise, little attention to their own health maintenance, and high rates of depressed mood. Unfortunately, this trend often continues even after graduation, becoming a lifestyle pattern of unhealthy behavior.

Physiatry has the unfortunate distinction of having the third highest levels of reported burnout. Physician burnout is associated with increased medical errors, impaired professionalism, reduced patient satisfaction, depression and suicidal ideation, motor vehicle accidents and near-misses. There are an estimated 400 physician suicides per year at a rate 1.9 times the average population. This makes us one of the highest rates by occupation to commit suicide.

The issue of stress and burnout among residents and attendings has become important to the ACGME, who has recently joined the National Academy of Medicine’s “Action Collaborative on Clinician Well-Being and Resilience.” ACGME has created a resource page with tools to identify burnout, promote well-being, address emotional and psychological distress, improve the learning and work environment, and cope with tragedy. At the AAP’s 2018 Annual Meeting, there was a strong emphasis on resident wellness. Lectures including “Wellness in Rehabilitation” and “Preventing Burnout” and “Combating burnout among physiatrists” helped define the issues and provide strategies to address them. Wellness was also a hot topic among special interest groups, such as the Residency and Fellowship Program Directors.

As a result of this increased awareness and education, the program leadership at Burke Rehabilitation Hospital implemented our First Annual Resident Wellness Day based on ideas learned during Physiatry ’18. Residents were excused from clinical duties for six hours, during which time they were provided yoga and mindfulness sessions and massages. They also participated in discussions on improving emotional intelligence, identifying burnout and depression, managing stress and developing resilience. Residents completed the Maslach Burnout Inventory, which showed moderate burnout among the Burke residents. These results will be tracked over time. The day concluded with a dynamic meditation session from a life coach who shared additional stress-reduction strategies.

In order to maintain the momentum, we have created a Wellness Committee, which will include residents, attendings, therapists and nursing staff. This committee will meet monthly to arrange activities that will promote a greater sense of mental and physical well-being. We believe promoting such practices among all employees will promote a hospital-wide wellness culture. We are grateful for the guidance of the AAP, ACGME, AMA, and AAMC in helping us develop our First Annual Resident Wellness Day. We look forward to hearing about similar programs from our nationwide physiatry family so that we can all learn from each other.

References:
10. International for Occupational Safety and Health, CDC.
11. Wellness in Rehabilitation”. Jonas Sokolof, Jeffrey Krauss, Marni Hillinger, Elizabeth Frates. AAP 2018 annual conference presentation
12. “Preventing Burnout”. Christopher Garrison and James Silva. AAP 2018 annual conference presentation
13. “Combating burnout among physiatrists” Gerard Francisco. AAP 2018 annual conference presentation

USEFUL RESOURCES:
http://www.acgme.org/What-We-Do/Initiatives/Physician-Well-Being
https://www.aamc.org/initiatives/462280/well-being-academic-medicine.html
EPAs and OPAs

– Acronyms That Are Worth It!

By: Michael Mallow, MD, Member of the AAP’s Education Committee
Alex Moroz, MD, MHPE, Vice Chair of the AAP’s Residency and Fellowship Program Directors (RFPD) Council

We are swimming in new acronyms daily, and it’s reasonable to be automatically turned off by the “next thing” in education. But bear with us and consider adding one (okay, two) acronyms to your lexicon, if they are not there already.

**Entrustable Professional Activities (EPAs)**, a concept developed by Olle ten Cate, are observable units of professional practice that provide a link between competency-based medical education and clinical practice.¹ A set of EPAs represents the work of a profession, separated into distinct observable activities. For example, the EPA “Evaluating and managing patients with spinal cord injury and other spinal cord disorders including secondary conditions and complications” encapsulates a set of patient care activities that physiatrists are entrusted to perform.

Achieving an EPA is intended to represent a meaningful step in training and a moment where a learner is allowed to practice that activity with less supervision. It is suggested that 10 activities per year of training are a reasonable number to master.² EPAs have been developed and validated for multiple specialties, including Physical Medicine and Rehabilitation,³ and are the subject of robust investigation in Undergraduate Medical Education.⁴

**Observable Practice Activities** (OPAs) are smaller elements of work that can describe the activities that build to an EPA. For example, “Performing a botulinum toxin injection” is a potential OPA that would nest under the EPA “Evaluating and managing patients with spasticity”. The vision for an EPA/OPA curriculum is well articulated by Choe et al.⁶ The authors describe a curriculum where a given rotation is focused on 8-10 nested OPAs. This design can provide trainees with clear expectations for the learning experience and offer faculty points of emphasis and, significantly, specific and predetermined targets for direct observation and feedback. Assessment of these OPAs is performed with an entrustment scale, and these results are mapped to the milestones. This step, mapping of EPAs and OPAs to competencies and milestones, is significant in allowing EPAs to work in conjunction with the existing structure of competency-based medical education.

The AAP is actively engaged in the process on behalf of our field and training programs. The EPA/OPA Sub-Committee of the Education Committee is developing OPAs for use in residency training in PM&R. Through the work of a dedicated group of educators, we are creating sets of OPAs that can nest under each EPA. These will hopefully be useful as relatively straightforward ways to incorporate these concepts into training programs. These OPAs can, of course, be modified, or new activities created, at each program and on each rotation. Through the Sub-Committee, we are also collecting data on the use of OPAs in multiple residency programs.

In closing, think of the resident that just completed your rotation and ask yourself how would they answer this question: “what did you learn on the rotation”? Would he or she recite the goals and objectives? Or, would he or she instead describe specific patient care tasks, potentially related to particular diagnoses that occurred during the rotation? Individual milestones and objectives under a single competency are a vital element of curricular construction. However, a holistic EPA or OPA, which naturally encompasses the performance of multiple competencies, can perhaps better describe what we are trying to achieve in graduate medical education, while at the same time providing clear targets for progressive responsibility and entrustment through observation-based assessment and feedback.

References:
WELL-BEING FOR COORDINATORS: BALANCING STRESS

• Figure out what is causing your stress: Do you have too many commitments making you irritable and tired? You can always say NO! It is crucial to figure out what is causing your stress and minimize it.

• Schedule your time: Having a set schedule for your day-to-day work-life can be beneficial for prioritizing your downtime as well as your dedication time.

• Make a decision: After making a schedule, take a good look at it. Is there anything you can take out that is wearing you down? This is a great way to figure out your priorities and what is most important.

• Talk to a friend or family member: Use the most important people in your life to express your feelings in a no-judgement-zone. Friends and family can provide needed reassurance, while also lending a hand to help with your busy schedule.

• Take time for yourself: Get away from your responsibilities and do something relaxing for yourself. Attend a yoga class, go shopping or maybe plan a weekend trip.

• Exercise: Exercising is the perfect way to release stress and cultivate a sense of peacefulness within. You will feel confident and energized to take on your challenges.

PROPOSED NEW COMMON PROGRAM REQUIREMENTS – EFFECTIVE JULY 1, 2019

The proposed New Common Program Requirements for Sections I – V are under review. Should they be approved, review to start planning to implement in your program. Please note that the proposed new CPRs are separate for Residency and Fellowship.

Summation for Section I is provided below. The summations for Sections II-V will be published in future editions. All summations were done by Wendy Helkowski, MD, Program Director at University of Pittsburgh Medical Center. You can find the current and proposed CPRs at www.acgme.org.

Section I: Oversight

• Diverse workforce (residents, fellows, faculty, staff)
• Lactation facilities
• Fellows must contribute to education of residents in core program (if present)
• Program must ensure resident well-being

Join us at the next AAP Annual Meeting in San Juan, Puerto Rico, February 19-23, 2019! Contact Cindy Volack with ANY ideas and/or to present at volackc@nyp.org.

Chair: Tammie Wiley Rice – twileyr@med.umich.edu
Chair Elect: Nicole Prioleau – npriole1@jhmi.edu
Immediate Past Chair: Coretha Davis, BS – cdavis@med.miami.edu
Program Director/Secretary: Cynthia Volack – volackc@nyp.org
Newsletter Editor: Stacey Snead-Peterson, MS – sneadpetersons@upmc.edu

WELCOME TO NEWLY MATCHED RESIDENTS!

Physiatry was one of four specialties that matched at 100% in 2018. We look forward to welcoming and celebrating your new PGY-1’s as AAP members and Physiatry ‘19 attendees.
We represented the AAP alongside its Executive Director Tiffany Knowlton at the Association of American Medical Colleges (AAMC) Council of Faculty and Academic Societies (CFAS) Spring Meeting, April 19-21, 2018. The meeting included a special celebration of Dr. Darrell Kirsch, the AAMC’s President and CEO, who is stepping down in June 2019. Here are key takeaways that can support your career and institution:

**WELLNESS AND BURNOUT**

Physician burnout is increasing nationally, up 9% from 2011 (45% burnout) to 2014 (54% burnout) [Shanafelt, Mayo Clinic Proceedings 90:1600]. Four hundred physicians die by suicide each year, a rate double that of the general population. Physician rates of depression remain alarmingly high at 39%. Physician wellness also affects our patients: the impact on quality of care is significant.

- **Surgical Errors:** “Each one point increase in depersonalization was associated with an 11% increase in likelihood of reporting an error while each one point increase in emotional exhaustion was associated with a 5% increase” [Shanafelt et al Ann Surg. 2010; 251:995-1000].

- **Medication Errors:** “Depressed residents made 6.2 times as many medication errors per month as residents who were not depressed” [Fahrenkopf et al. BMJ. 2008; 1; 336(7642):488-91].

- **Infections:** “Nurse burnout remained significantly associated with urinary tract infection (0.82; P=0.03) and surgical site infection (1.56; P<0.01). Hospitals in which burnout was reduced by 30% had a total of 6,239 fewer infections, for an annual cost savings of up to $68 million” [Cimiotti et al. Am J Infect Control. 2012;40(6):486-90].

How can we protect the health of our own providers? How can we protect our patients? The National Academy of Medicine has launched an Action Collaborative and the AAP is proud to support it. Learn more and get involved at https://nam.edu/clinicianwellbeing.

**GENDER DISCRIMINATION AND IMPLICIT BIAS**

Gender discrimination is common in STEM fields. In medicine, women are underrepresented at all levels of leadership, promoted at lower rates, have less opportunity for experiences that would aid in career advancement, and are more likely to have work-life imbalance. What’s more, health care ranked as a top industry for reports of sex-based discrimination to the Equal Employment Opportunity Commission in 2016. How can we change this culture?

- Nip aggressive behaviors in the bud
- Create a culture where it’s safe and expected for witnesses to speak up
- Have women in positions across the hierarchy
- Training in what constitutes harassment, as well as why diversity is important in race/ethnicity, gender, sexual orientation, etc.
- Investigate every complaint with clear and due process
- Review the National Practitioner Databank

**OTHER TOOLS**

Access best practices for standardized residency interviews (bit.ly/aamcSRI), AAMC leadership courses (aamc.org/leadership), data for workforce planning (aamc.org/data), and meeting recaps and resources (aamc.org/members/cfas/resources). You can also join us at the AAMC’s Annual Meeting, November 2-6, 2018 in Austin, TX.
CONGRESS MOVING FORWARD WITH OPIOID ABUSE LEGISLATION

Congress is aggressively moving forward with a new legislative package to address the opioid abuse crisis. These new proposals come following the enactment of the Comprehensive Addiction and Recovery Act in 2016 as Congress’s first attempt to combat opioid abuse. Lawmakers are expected to pass a new package before they recess for the midterm elections in November.

The Senate Health, Education, Labor and Pensions (HELP) Committee was the first to approve a package in late April. The legislation, called the Opioid Crisis Response Act of 2018, would provide reforms at the National Institutes of Health (NIH) and the Food and Drug Administration (FDA) to improve opioid related research and development of non-opioid alternatives to pain treatment. In addition, the bill includes several provisions that would expand the authority of the Substance Abuse and Mental Health Services Administration (SAMHSA). Among the several provisions dealing with SAMHSA is a directive to examine the impact of federal and state laws regulating the length, quantity or dosage of opioid prescriptions. This would require the Secretary of HHS to issue a report on these laws, including the impact on overdose rates, diversion and individuals for whom opioids are medically appropriate. In addition, SAMHSA would examine alternatives to opioids by allowing them to support hospitals and other acute care settings seeking to manage pain without using opioids. This would require the Secretary of HHS to provide technical assistance related to the use of alternatives to opioids, including for common painful conditions and certain patient populations, such as geriatric patients, pregnant women and children.

Additional provisions include directing the Centers for Disease Control and Prevention (CDC) to advance awareness regarding the risk of misuse and abuse of opioids. This program would disseminate information to providers and the public (including about prescribing and dispensing options related to partial fills of controlled substances); support provider education, including through prescribing guidelines; and provide a provision to encourage states to share PDMP data with one another. This would streamline federal requirements for PDMPs so doctors and pharmacies can know if patients have a history of substance use and opioid abuse. A complete listing of the provisions included in this package can be found at http://bit.ly/OpioidCrisisResponseAct.

Most recently the Senate Finance Committee approved a package of 22 additional bills to address the opioid epidemic. Among the pieces of legislation is a provision that would enhance patient access to non-opioid treatment options. The House Energy & Commerce Health Subcommittee approved a package of 57 bills in late April which focused on ways to address the crisis. A few of the bills to highlight include a provision to incentivize post-surgical injections as a pain treatment alternative to opioids by reversing a reimbursement cut for these treatments; and to create a temporary pass through payment to encourage the development of non-opioid drugs for post-surgical pain management in Medicare. Another bill would require CMS to, in consultation with stakeholders, establish a threshold, based on specialty and geographic area, for which a prescriber would be considered an outlier opioid prescriber. CMS would then be responsible for notifying prescribers identified as outliers of their status. Finally, a bill was added to clarify telemedicine waivers for opioid prescriptions. Federal law permits the Attorney General to issue a special registration to health care providers to prescribe controlled substances via telemedicine in legitimate emergency situations, such as a lack of access to an in-person specialist. Unfortunately, the waiver process has never been implemented through regulation, and some patients do not have the emergency access they need to treatment. This bipartisan draft directs the Attorney General, with the Secretary of Health and Human Services, to promulgate interim final regulations within 30 days of passage of the law. A complete listing of bills can be found at http://bit.ly/OpioidsLegislation.

Both the House Ways & Means and Energy and Commerce Committees are expected to advance separate legislative packages which could ultimately be combined for final House passage. The Ways & Means Committee released its package of bill which can be found at http://bit.ly/WMOpioidBills. This final package is then expected to be merged with the package that passes the Senate into a comprehensive bill.
These new initiatives at the American Journal of Physical Medicine & Rehabilitation (AJPM&R) will expand the scope and reach of scientific knowledge!

**FOCUSED EVIDENCE-BASED CONTENT**
Coming in July is a new monthly section called “Evidence-Based Physiatry.” This section will give you information and practices on the best scientific evidence available, including quarterly reports from Cochrane Rehabilitation.

**SOCIAL MEDIA PRESENCE**
Get cutting-edge research in your Twitter feed by following @AJPMRjournal! Engage with interdisciplinary colleagues around the globe in a vital and viral way. Join the conversation and contribute your research — it may be featured on social media!