Q. What is READI?
A. PM&R READI is an acronym for Physical Medicine and Rehabilitation Residency Expansion And Development Initiative that we created. It is a consultancy program sponsored by the Education Committee of the Association of Academic Physiatrists aimed to increase the number and quality of PM&R residency training programs in the nation.

Q. How does the process work and how long does a consultation usually take?
A. The process is initiated when an institution approaches the AAP either directly or through an online form on the AAP website to garner guidance on how to create a new PM&R residency, expand a current PM&R residency, or improve the quality of a current PM&R residency. The Chair of the AAP Education Committee assesses the situation and, along with a senior AAP administrator, contacts the requesting institution for an initial assessment of needs. The Chair then determines the degree of intervention required. It could range from just phone calls and emails to an on-site visit. For on-site visits, the Chair would request a senior and junior national experts on GME processes to participate. The on-site visit would last a few days with follow up phone calls or emails. After the on-site visit, the visiting team develops and provides the institution a comprehensive assessment and recommendation.

Q. Describe the infrastructure of the organization that participated in the pilot program.
A. The program that participated in the pilot...
program was an established university with an established medical school that was desirous of creating multiple residencies. READI was consulted to advise on the creation of a PM&R program. The medical school was community based and did not have its own medical center. Collaboration was required between the medical school and four competing hospital systems that decided to strategically join forces as a Consortium in creating a mutually shared GME structure with residency programs.

Q. What did the institution expect in terms of outcomes for READI?
A. The Consortium members expected PM&R READI to provide them with a feasibility assessment that included teaching staff, administration support, infrastructure, logistics, responsibilities, patient characteristics, and volume. They also requested information on ‘must-haves’ and critical processes. PM&R READI also provides recommended implementation timelines.

Q. What obstacles did you overcome? How did you overcome them?
A. Working with the medical school along with four competing hospitals presented issues with scheduling and differentiating levels of commitment. We ended up speaking to several physicians on the phone after the on-site visit.

Q. How do you measure the success of READI?
A. One way to measure the effectiveness of the PM&R READI program is to utilize post-consultation surveys. Another measure of success is the actual creation or expansion of the program being assessed.

Q. What kinds of institutions can participate?
A. Any academic or private institution interested in creating a new PM&R residency program, expanding their current program, or improving the effectiveness and quality of their current program can participate in PM&R READI.

Q. Can READI be adapted in order to fit other specialties?
A. Yes, the process is the exact same for any specialty.

Q. How can an institution apply for a READI program evaluation?
A. Any interested institution can apply for PM&R READI by contacting the AAP at www.physiatry.org/READI.

A TIME FOR VIRTUES, VALUES, AND PRINCIPLES

In the wake of recent turmoil and unrest globally and in the United States post-elections, a time of reckoning is upon us. It may be the best of times or the worst, depending on one's Dickensian persuasion. One thing, which remains clear, however, is that it is a time for somber reflection about the core values and principles that unite rather than divide us as a society.

As a profession, physicians have been at the forefront of upholding the virtue of compassion—caring for the sick in their most vulnerable moments—and the values of objective scientific inquiry and scholarship—pushing the boundaries of knowledge and innovation.

With a focus on the care of individuals with disabilities, physiatrists have traditionally filled major gaps in addressing the needs of an often-neglected segment of the population. At a time when there is an imminent threat of repealing the Affordable Care Act (ACA), our patients and families face an uncertain future about their healthcare needs and associated costs.

Healthcare expenditure is projected to reach close to 40% of the United States gross domestic product by 2040. As a specialty defined by the principles of restorative function and qualitative improvement, we must lead the charge to bring treatments that provide the right patient-oriented outcomes at affordable costs.

This year, one milestone of the AAP Resident / Fellow Council is the initiation of a rehabilitation technology project, highlighting innovative ways technology is helping improve the lives of our patients. Whether it is using wearable devices to track outcomes or applying virtual reality to augment neurorecovery, our specialty has the rare opportunity to spur creative life-affirming transformations.

Interested contributors for the Rehabilitation Technology Project can contact George Marzloff at george@marzloffmedia.com.

Amidst a time of chaos, we anticipate that values bringing meaningful outcomes to patients and families will help keep us ahead of the value-cost curve. Now is the time to revive the virtue of compassion and the principle of functional restoration deeply embedded within the DNA of our specialty.

Charles A. Odonkor, MD, MA
AAP RFC Chair
Hello Colleagues,

Fifty years ago the AAP was born out of a vision by a small group of Physiatric leaders led by Dr. ‘Ernie’ Johnson to promote methods of undergraduate and graduate teaching of the art and science of physical medicine and rehabilitation (PM&R). Under the leadership of eight board members, the AAP grew its membership of 63 in 1970, to 1,106 members in 1994. Over the years countless committed academic physiatrists nurtured its growth into the “academic home of physiatry.” In the last ten years alone, the creativity, industry, and diligence of our members, leaders, and staff yielded numerous achievements:

- **Training Programs** – AAP developed and implemented the Program for Academic Leadership (PAL), Rehabilitation Medicine Scientist Training Program (RMSTP), Rehabilitation Research Experience for Medical Students (RREMS), and Medical Student Summer Clinical Externships (MSSCE).

- **Public Policy Committee** - AAP launched a new committee and hired an expert lobbying firm dedicated to advocating on issues related to research conduct and funding, undergraduate medical education, and other related issues.

- **Growth of Membership** – AAP’s membership skyrocketed and currently represents over 1,600 PM&R professionals.

- **Increase of Annual Meeting Attendance** – AAP hosted 611 attendees at the 2012 AAP Annual Meeting in Phoenix. Over 1,000 participants have already registered for the upcoming 2017 AAP Annual Meeting in Las Vegas.

These accomplishments make our 50th Anniversary Celebration at AAP 2017 Las Vegas even more special. Anniversaries inspire nostalgia and help us to reflect on what once was – using the lessons of history as a compass for our future. In spite of our accomplishments, we can always do more to support the evolution and relevance of academic physiatry.

To this end the AAP has committed to cultivate diversity among our ranks and other initiatives. To start, I appointed a Task Force on Advancing Women in Academic Physiatry to thoughtfully investigate ways we can support the academic careers of our female colleagues. I am still baffled - and I confess, embarrassed - by the fact that in the last 50 years there have been only two female AAP presidents.

I am the first AAP President of Asian descent and an African-American or Hispanic has not led our Association to date. At its semi-annual meeting, the AAP Board of Trustees agreed that once the Women’s Task Force is up and running, we shall tackle the issue of racial diversity within our organization and leadership structure. By facing these issues head on, we can proactively problem-solve and create new opportunities for our members.

And speaking of diversity in academic physiatry, the AAP has also made its first steps in reaching out to the global PM&R - or PRM as our specialty is called elsewhere in the world - community by raising awareness of the AAP’s role as the ‘academic home’ of physiatrists. We have as much to learn from as to share with our fellow physiatrists from around the world. A giant stride the AAP made this past year is winning the hosting rights for the 2020 Congress of the International Society of Physical and Rehabilitation Medicine (ISPRM). That meeting, attracting thousands of PRM specialists globally, will be the AAP’s debut as an international resource for academic physiatry.

By any standard the AAP is a small specialty-specific organization, but in its first 50 years it has carved a unique niche in academia. It has served as a breeding ground for academic leaders in our field, and promoted interest in academic physiatry. Its growth, paralleled by the advancement of PM&R, is a testament to the power of collaboration and dedication of many individuals to transform a vision to promote academic physiatry into a living action plan. The AAP’s rich 50-year history is history worth repeating itself.

Warm Regards,

Gerard E. Francisco, MD
Association of Academic Physiatrists, President
2017 Annual Meeting

FEBRUARY 7-11, 2017 | LAS VEGAS

REGISTER TODAY AT PHYSIATRY.ORG/AAP2017
Your registration includes meals and much more!

• Complimentary networking breakfast, lunch, and coffee service Thursday-Saturday
• Access to ALL educational sessions Thursday-Saturday (no hidden fees)
• Reduced group hotel rates at the Mandalay Bay Resort and Casino and The Delano Hotel
• Access to all 50th Anniversary Events
• Admittance into the President’s Welcome Reception, Exhibit Hall, Poster Gallery Receptions, Fellowship & Job Fair, and Awards Ceremony
• Conference App and WiFi throughout meeting space

PLENARY SPEAKERS
Meet the 2017 AAP Annual Meeting Plenary Speakers who are helping to revolutionize the field of academic physiatry around the globe.

THOMAS NASCA, MD, MACP
Thursday – February 9, 2017
ACGME: Leveraging Resources to Support Physician Well-Being

CHAD BOUTON
Friday – February 10, 2017
Neural Bridging: Reconnecting Mind and Body

CHERI BLAUWET, MD
Saturday – February 11, 2017
More Than Just a Game: The Public Health Impact of Sports and Physical Activity for People with Disabilities

“I am most excited to meet and chat with like-minded professionals, to share insight and ideas, and to hear from the three plenary speakers who embody innovation, education, and collaboration.”
HELP CELEBRATE AAP’S 50TH ANNIVERSARY

1987
AAP Attendees ran, walked, and rolled to support the Foundation of PM&R at the 1987 AAP Annual Meeting in San Diego. Browse the AAP 2017 Itinerary Planner to discover all educational and networking events offered this year!

1995
Attendees enjoyed the sights and a bike ride at AAP 1995 in Scottsdale, Arizona. AAP 2017 Las Vegas offers fun outdoor activities as well as the Las Vegas Strip with entertainment, food, and casino games.

2010
Attendees claimed CME at AAP 2010 in Bonita Springs. Attendee can enjoy the highly anticipated sessions and claim up to 30 AMA PRA Category 1 Credits™ at the 2017 AAP Annual Meeting.

“This is one of those meetings where you feel like you are learning from each other. The interactive sessions and workshops are invaluable to me.”

OVER 1,000 ATTENDEES HAVE ALREADY REGISTERED
View the current attendee breakdown for AAP 2017 Las Vegas.

42% PRACTICING PHYSIATRIST

39% PM&R RESIDENT OR FELLOW

10% PROGRAM COORDINATOR OR ADMINISTRATIVE DIRECTOR

9% MEDICAL STUDENT

BOOK YOUR HOTEL ROOM
The Delano and Mandalay Bay Resort and Casino are the host hotels for the 2017 AAP Annual Meeting. Located on the edge of the world-famous Las Vegas Strip, AAP 2017 hotels are conveniently located within the AAP 2017 meeting rooms in the Mandalay Bay Convention Center.

VISIT PHYSIATRY.ORG/REGISTER
TIS THE SEASON OF BEHAVIORAL INTERVIEWING

By now all programs are hard at work interviewing candidates for their respective programs. Recently, applicants have become much more similar in terms of letters of recommendations, personal CVs, and Board Scores – all seem to be outstanding and the interview doesn’t seem long enough to give proper insight to the applicant.

It’s time to say ‘goodbye’ to the vague and overused ‘what are your strengths and weaknesses’ style questions and ‘hello’ to a 45% more predictive Behavioral Interviewing Technique. This technique forces the interviewer to ask questions specific to certain behaviors and look at past performance as the best predictor of future performance.

FOR THE INTERVIEWER:
How to Conduct a Behavioral Interview

Before the interview, take some time to identify job-related experiences, behaviors, knowledge, skills, and abilities that your institution decides are desirable such as: critical thinking, being a self-starter, willingness to learn, willingness to travel, self-confidence, teamwork, or professionalism. The Association of American Medical Colleges (AAMC) Handout of Best Practices for Conducting Residency Program Interviews is also a great resource for Do’s and Don’ts of Interviewing.

During the interview, ask pointed questions to elicit detailed responses aimed at determining if the candidate possesses the predetermined characteristics. Example scenario questions can be: ‘Tell me about the time…’ or ‘Describe a situation…’ Considering the interviewees’ answers, try to pinpoint specific behaviors and probe further for more depth or detail such as “What were you thinking at this point?” or ‘Lead me through your decision process.’

FOR THE INTERVIEWEE:
How to Succeed in a Behavioral Interview

Prior to the interview, identify 6-8 examples from various and timely past experiences where you demonstrated top behaviors and skills typically sought. Half of the examples should be positive overall (accomplishments or meeting goals); the other half should start out negatively but either ended positively or result in making the best of the situation.

During the interview, briefly describe the situation, what specific action you took to have an effect on the situation, and the positive result or outcome. Frame it in a three-step process, usually called a S-A-R (Situation-Action-Result). Your responses need to be specific and detailed. Candidates who discuss particular situations that relate to each question will be far more effective and successful than those responding in general terms.

The interviewing responsibility of a Residency & Fellowship Program Director is no small task, often plagued with questions like ‘How do we prepare for a successful interview season’ and ‘What is the best way to rank the prospective resident/fellows for the next class of doctors to educate?’ I have found the Behavioral Interviewing Technique – or a version of it mixed with traditional interviewing – to be most successful in confidently selecting candidates.

Residency Interviews will be one of the many topics discussed at the 2017 AAP Annual Meeting in Las Vegas, February 7-11, 2017. It’s not too late to register – physiatry.org/Register. I hope to see you all this February but until then I wish you all a happy and productive new year.

Rita G. Hamilton, DO
Residency Program Director
Physical Medicine and Rehabilitation
Spinal Cord Injury Medicine
Baylor Institute for Rehabilitation
Association of American Medical Colleges (AAMC) Council of Faculty & Academic Societies (CFAS) Update

Drs. Dani Perret Karimi (University of California, Irvine) and Laura Kezar (University of Alabama, Birmingham) attended the AAMC Learn Serve Lead 2016 Annual Meeting in Seattle, Washington and served as AAP representatives to CFAS.

A focus on faculty resilience was present on the CFAS networking day, where Dr. Perret joined the AAMC Faculty Resilience Working Group. A new AAMC Well-Being initiative was highlighted as a resource for AAMC societies and institutions. The initiative includes a large collection of resources and AAMC Well-Being Index - a collection of well-being programs initiated by medical schools and teaching hospitals.

Additional key topics covered at the meeting included quality/safety, opioid prescribing, mistreatment, diversity, basic science support, Veterans Affairs system collaborations, and innovation in academic medicine.

The opening plenary session by presidential historian Doris Kearns Goodwin provided a refreshing insight on many past United States Presidents, adding illuminating narrative on the personal and public challenges of our past leaders and the impressive resilience that ultimately led to their effectiveness.

Additional plenary sessions included AAMC President and CEO, Darrell Kirch, MD, who celebrated 10 years with the AAMC and reaffirmed academic medicine as a public service commitment. Atul Gawande, MD presented 'Being Mortal: The Challenging Role of Medicine and the Clinician' and echoed public service, stating that regardless of politics, hospitals are intrinsic parts of their communities. He also provided insight on the role of checklists, policies and procedures, and efficacy in the never-ending quest for quality in medicine.

The AAMC encourages new administration to ensure continued health care access for Americans. This is an important role of Deferred Action for Childhood Arrival (DACA) students, Medicaid coverage issues, Title 7 programs, National Institute of Health (NIH) research funding/stability, Graduate Medical Education (GME) expansion funding and the inequity of Medicare quality programs in penalizing academic medical centers, who treat the most medically complex and underserved populations.

Despite these concerns, Dr. Kirch and the AAMC remain cautiously optimistic, viewing every concern as an opportunity. With new administration, a focus on infrastructure is expected; our physician workforce, especially in the context of our current aging population should be viewed as part of our national infrastructure.

We should celebrate that this infrastructure brings together a diverse cross-section of Americans- both healthcare providers and the patients that we serve.
The Association of Academic Physiatrists (AAP) was founded in 1967 in response to a letter from Dr. Ernest Johnson to about 20 academically affiliated physiatrists. Its purpose was to stimulate interest in and share expertise related to undergraduate and graduate academic physiatry. An organization with a strong academic orientation and involvement of its members was needed to gain representation in the Council of Academic Societies (today known as the Association of American Medical Colleges—AAMC). The AAP was selected to be a member of the AAMC in 1970. Dr. Johnson is considered to be the Founding Father of the AAP. It is the premier academic physiatry professional society in the United States and in the world. It is the only major PM&R Society/Association with Physiatry in its name. The major focus of the AAP is academic affairs and administration, undergrad, graduate, and continuing medical education, as well as research. It strives to train and develop the academic base of the specialty. One of the many strengths of the AAP are the Councils (Chairs, Program Directors, Residents/Fellows, Medical Student Educators, Residency Coordinators, and Administrative Directors). These special forums are ideal for networking, mentoring, education, and problem solving. Research was a Council, but is now a Committee.

I completed my residency in 1975 at the University of Washington School of Medicine, and was advised by Drs. Walter Stolov and George Kraft to join the AAP when I joined the Department’s faculty in 1986. During my residency I made the decision to have a career in Academic medicine, as opposed to private practice with the ultimate goal to become a Department Chairperson. My Board Certificate number is 1261. It was truly a very small specialty. The AAP offered me the opportunity to meet leaders in the specialty such as Ernest Johnson, Fritz Kottke, John Ditunno, John Melvin, George Koepke, Henry Betts, and Joe Goldgold. Each served as a mentor. They were all willing to answer questions. The organization was willing to allow new members the opportunity to serve on committees, and to see different leadership styles.

I incorporated many of the organizational and leadership traits I most admired into my approach of being a medical school Department Chairperson. It allowed me to develop a peer group of potential leaders in the field that positively influenced my career. I was always concerned about resident education, and the evaluation of clinical competency. Discussions during my resident training, and early faculty career more than convinced me that the field needed a current more comprehensive textbook. This resulted in Rehabilitation Medicine: Principles and Practice, first edition published in 1988. The textbook has 104 contributors, most of which came from interactions at the AAP. I believe that the same opportunity for career development is available today, for the next generation of physiatry academic leaders.

In addition to the AAP Annual Meeting, AAP has developed training programs such as the Program for Academic Leadership (PAL), Rehabilitation Research Experience for Medical Students (RREMS), Medical Student Summer Clinical Externships (MSSCE), and the Rehabilitation Medicine Scientist Training Program (RMSTP). It also has the Research Consultancy Program designed to advise Departments who want to build research capacity. All of these special programs help to develop and mentor young physiatrists, as part of the academic development process. This is the opportunity and forum for developing lifelong support and mentorship.

The AAP has been the most important professional organization in my career. It has allowed me to develop the skills needed to chair and lead the American Board of Physical Medicine and Rehabilitation (ABPMR), American Board of Medical Specialties (ABMS), the Education Commission for Foreign Medical Graduates (ECFMG), the American Association of Electrodiagnosis and Electromyography (AAEE), and the International Society of Physical and Rehabilitation Medicine (ISPRM).

I look forward to this 50th Anniversary, an opportunity to unite with colleagues who worked very hard these past 50 years, and to hear of the future plans for this great association.

Respectfully Submitted,
Joel A. Delisa, MD, MS
AAP Newsletter Editor
21st Century Cures Act Signed Into Law

In the final days of the 114th Congress, lawmakers passed, and the President has signed, sweeping legislation that would boost funding for both the National Institutes of Health (NIH) and the Food and Drug Administration (FDA) and strengthen the infrastructure of both agencies in hopes of getting medical cures and treatments to patients quicker.

The bill, H.R. 34, known as the 21st Century Cures Act, has been designed to bring health care innovation infrastructure into the 21st Century, in order to deliver hope for patients and loved ones by providing necessary resources to researchers to continue their efforts to uncover the next generation of cures and treatments. The bill has been a priority for House Energy and Commerce Committee Chairman, Rep. Fred Upton (R-MI) and a senior Democrat on the Committee, Rep. Diana DeGette (D-CO) since 2014. The far-reaching almost 1000 page legislation includes AAP supported language to strengthen the rehabilitation research portfolio at NIH, as well as the other following highlights:

Rehabilitation Research Provisions:
• Specifies that NIH must update their Rehabilitation Research Plan periodically, or at least every five years, and requires the agency to develop objectives and benchmarks that will allow NCMRR to measure success and report to Congress on annual progress. The report shall (1) include recommendations for revising and updating the Rehabilitation Research Plan, (2) identify existing resources to support the purposes of the center, and (3) ensures coordination and periodic review of the state of medical rehabilitation science and outreach to the research community in connection with revisions to the research plan.

• Encourages coordination of medical rehabilitation research among agencies of NIH and other federal agencies, including through interagency agreements.

• Defines the term “medical rehabilitation research” to mean the science of mechanisms and interventions that prevent, improve, restore, or replace lost under-developed, or deteriorating function.

Additional Provisions of Note:
• Directs NIH to utilize its prize authority to support innovation prize competitions to advance biomedical science and improve health outcomes for diseases that are serious and represent a significant burden in the U.S.

• Encourages the Secretary of Health and Human Services (HHS) to carry out a “Precision Medicine Initiative” to augment efforts to address disease prevention, diagnosis, and treatment.

• Creates a “Next Generation of Researchers Initiative” in the Office of the Director at the NIH to coordinate, develop, modify, and prioritize policies and programs to improve opportunities for new researchers.

• Requires NIH to report to Congress on any actions taken in response to recommendations from the National Academy of Sciences as part of the study on policies affecting the next generation of researchers.

• Requires the Director of NIH, in consultation with the directors of the national research institutes and centers, to develop a six-year coordinated strategy to outline the direction of biomedical research investments made by the NIH, facilitate collaboration among the research institutes and centers, and advance biomedicine.

• Provides that the Secretary of HHS shall, as appropriate, improve the collection of information on the incidence and prevalence of neurological diseases and conditions, which may be through the establishment of a registry, in order to facilitate research and improve public health. This is intended to be carried out by the Centers for Disease Control and Prevention (CDC).

Funding Changes to Federal Agencies and Programs:
• Provides $4.8 billion over 10 years to the NIH for the Precision Medicine Initiative, the Brain Research Through Advancing Innovative Neurotechnologies Initiative (BRAIN Initiative), cancer research, and regenerative medicine using adult stem cells. (The funds are not mandatory and will be subject to annual appropriations.)

• Provides $500 million to the Food and Drug Administration (FDA) over 10 years to move drugs and medical devices to patients more quickly, while maintaining the same standard for safety and effectiveness.

• Provides $1 billion over 2 years for grants to states to supplement opioid abuse prevention and treatment activities, such as improving prescription drug monitoring programs, implementing prevention activities, training for health care providers, and expanding access to opioid treatment programs.

• Cuts $3.5 billion — about 30 percent — from the Prevention and Public Health Fund established under Obamacare.
Begin plans for resident graduation

- Graduation Dinners are usually held in June
- Have reservations already been made with a venue?
- Who should be invited? If not sure, check with Program Director or Chief Resident
- Does program provide graduation gift or plaque? Check with Program Director

Order graduation certificates

- Before placing the order, confirm resident/fellow’s name spelling, etc. with the trainee

Remind Program Directors to review status of each resident for promotion/graduation/renewal of contracts to be documented in resident’s permanent file

Begin budget preparation for next Fiscal Year (July-June)

- What is your role in this process? Discuss with your Program Director

Review your program’s policies

- Also check GME site for any new policies
- Replace any updated policies on your resident or program website

Review your program and rotation’s goals and objectives with your Program Director

- If edits are made, replace previous versions

Review program curriculum with your Program Director

- If edits are made, replace previous versions

Schedule Annual Program Evaluation (APE) Meeting for Spring

- Allow for 2-4 hours – Coordinator, Program Director, Key Faculty, Residents/Fellows must attend – check with Program Director
- Schedule End-of-Year CCC Meeting(s)
- Coordinator should attend. Program Director and key Faculty must attend

Remind fellows to meet with their Scholarly Oversight Committee (if programs requires)

Begin onboarding process for new Residents/Fellows scheduled to begin training in July

- Refer to Orientation section of Coordinator Manual

Osteopathic Programs - Osteopathic Internship match list submitted

MONTHLY TASKS

- Evaluations
  - Resident Semi-Annual Evaluations (January only)
  - Program Directors complete evaluations of faculty (January only)
- Duty Hour Reports
- Call Schedules
- Conference Schedules
- Goals & Objectives

Looking forward to seeing YOU in Viva Las Vegas!

Your AAP Coordinators’ Council Officers,
Coretha, Tammie, & Nicole
Immediate Past Chair: Kimberly Garza
Chair: Coretha Davis, BS
Chair Elect: Tammie Wiley Rice
Program Director/Secretary: Nicole Prioleau
Newsletter Editor: Stacey Snead-Peterson, MS
AAP Accepted into the SSS of the AMA:
In October, the Association of Academic Physiatrists (AAP) was officially accepted into the Specialty and Service Society (SSS) of the American Medical Association (AMA), made up of more than 130 national medical societies, military service groups, and professional interest medical associations. AAP was represented at the SSS for the first time by Samuel Chu, MD of the Rehabilitation Institute of Chicago (RIC), who attended the AMA House of Delegates (HOD) Interim Meeting in Orlando, Florida from November 12-15.

AAP will seek admission to the AMA House of Delegates through participation in the SSS to serve as the voice for academic physiatrists and to work closely with the delegations from the American Academy of Physical Medicine and Rehabilitation (AAPM&R), AANEM, and other relevant organizations.

AMA House of Delegates (HOD):
The AMA HOD is the principal policy-making body of the AMA. This democratic forum represents the views and interests of a diverse group of member physicians from more than 170 societies. These delegates meet twice per year to establish policy on health, medical, professional, and governance matters.

The policy-making process of the HOD is comprehensive, collaborative, and inclusive of all perspectives. Many groups of physicians come together to review and discuss existing and new policies prior to the HOD meeting. AAP participated in the PM&R caucus along with AAPM&R, AANEM, and other PM&R physicians, residents, and medical students attending the AMA. AAP also participated in the Academic Medicine Caucus and the SSS Meeting where physicians continued to examine each of the resolutions and reports on the docket for the HOD.

Policy Highlights:

AMA Prepared to Engage New Administration on Health Reform – AMA will actively engage the incoming Trump administration and Congress on the direction of health care reform. The HOD ‘reaffirmed its commitment to health care reform that improves access to care for all patients.’

Medical Education Policies – AMA adopted several policies aimed to alleviate medical student loan debt, integrate confidential physical health, mental health, and addiction treatment into training programs, and give physicians in training more leadership and community health work opportunities.

Maintenance of Certification and Licensing (MOC and MOL) – Emphasis was placed on MOC not being used to limit physicians’ ability to practice/deliver care by insurers, hospitals, or regulators.

Opioid Crisis Training Emphasis in GME – AMA adopted a policy to encourage the expansion of residency and fellowship opportunities to provide clinical experience in the treatment of opioid use disorders under the supervision of an appropriately trained physician.

Infertility Benefits for Wounded Veterans – AMA adopted policy to help change current practice that assisted-reproductive technology benefits, including IVF, are not covered by Veterans Health Administration, even though war injuries can cause infertility.

Stemming the Tide of Gun Violence – AMA joined an advocacy effort aimed at reducing gun-related deaths and injuries.

Breastfeeding Residents – AMA added stronger language to encourage residency programs to fully support the time, location, and secure storage for breastfeeding residents.

DACA – Delegates directed the AMA to issue a statement in support of US health professionals, including those training as medical students, residents, and fellows who are recipients of Deferred Action for Childhood Arrivals (DACA) status.

Care Team Leaders – AMA adopted a new policy that lays out the ethical obligations that physicians have to lead and participate in the team-based care model that research shows can improve health care quality and patient outcomes.
It's Not Too Late to Register for the 2017 AAP Annual Meeting

FEBRUARY 7-11, 2017 | LAS VEGAS

AAP 2017 Las Vegas brings together the leading minds in physiatry to share knowledge and expertise, advance science, promote education, collaborate with PM&R colleagues, and claim up to 30 CME Credits! 2017 AAP Annual Meeting Attendees will enjoy valuable courses, workshops, and keynote presentations focusing on PM&R research, education, and clinical practice.

Visit www.physiatry.org/Register and join 1,000 of the leading physicians in physiatry at the 2017 AAP Annual Meeting.