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## PRESIDENT'S LETTER

*By Kristjan T. Ragnarsson, MD*

### THE FUTURE OF ACADEMIC PM&R

The future of any medical specialty with presence at an academic medical center depends on several common factors, the most fundamental of which are financial resources, namely, money. If the clinical and research activities of faculty members do not produce sufficient income for the academic department, for the medical school and for the hospital, the future of the academic department will be bleak. Conversely, it goes without saying that financial success creates a degree of security and may permit growth of an academic department and greater income and various other benefits for its faculty members.

Where does the money come from? Medical Schools get most of their revenues from the faculty practices and from overhead charged to research grants. Investment income from endowments can be substantial, and annual fund raising may create new philanthropic contributions. Tuition fees are usually only a small portion of the school's income. Revenues for academic departments have much the same sources, but additionally they may receive payments from the medical school and/or hospital for faculty teaching, administration and even for some clinical services.

But money is not everything, when predicting the future of an academic department. Departments that generate large revenues can be at risk, if they appear to be poorly run, *e.g.*, if they fail to maintain a balanced budget and spend more than they earn, show no significant growth, do not comply with regulations, suffer adverse publicity, have weak academic programs, receive poor internal/external reviews with numerous citations, etc. Additionally, every medical and surgical specialty faces specific external and internal challenges that may affect its future. Every specialty has its own strengths and weaknesses and must identify and deal with opportunities and threats in a proactive manner.

So what is the future of academic PM&R? As a clinical specialty, we can be confident that both acute and chronic diseases as well as trauma will continue to cause disability and pain, the two main conditions that we treat using our rather unique therapeutic approaches. Competent and well liked physiatrists, whether they work in academia or in private practices, can rely on a steady stream of patients with these conditions for evaluation and management (E&M). Unfortunately, having a potentially unlimited stream of patients in need of our services does not guarantee financial success. Poor reimbursement by most third-party payors for E&M coded services forces

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clinicians to see a very large number of patients or to become more procedure oriented in order to generate sufficient income for themselves and for their academic department. Even reimbursement for procedures may be threatened, if scientific evidence does not exist for their efficacy, if they are deemed medically unnecessary or found by comparison to be no better than equally effective and less costly treatments. Academic PM&R departments may also suffer, if the academic hospital deems that the profit margin for inpatient and outpatient PM&R services is insufficient compared to other more lucrative clinical services. Hence, inpatient beds may be closed and outpatient services restricted or not allowed to grow. This could translate into fewer positions for academic physiatrists, less revenue for the department and reduced scope of services for PM&R out-patients. It is therefore of utmost importance that we monitor closely legislative activities which may affect payments to physicians and hospitals by federal and state payors. We must also actively participate in negotiations with private health insurance companies to ensure optimal reimbursement for all our clinical services. We must be ready to write or call our elected representatives, when we feel that reimbursements for physician and hospital services are being reduced, and argue how such development would threaten the provision of care for our patients and the operation of the academic department.

New legislations and regulations have brought both benefits and hardship to PM&R. The inclusion of inpatient and outpatient rehabilitation medicine services in the Medicare/Medicaid legislation during the mid 1960s was a positive development, which truly put the field of PM&R on the map and made its services an essential part of medical care. Another positive development for PM&R occurred during the 1980s when the implementation of diagnostic related

grouping (DRG) reimbursement system for acute medical and surgical hospital admissions resulted in rapid and significant reduction in length of stay (LOS) and increased number of empty acute beds. With excess bed capacity, many acute hospital units were closed or converted to inpatient rehabilitation facilities (IRF), which were exempt from DRG for many years. In a little more than a decade, IRF beds in the U.S. almost tripled in number and many of the new IRF beds were located at academic medical centers.

*Implementation of the 75% (60%) rule continues to be a major threat...*

The implementation of a prospective payment systems (PPS) for inpatient rehabilitation facilities did not have the widely anticipated negative effect as provision of our services had become more efficient with significant reduction of LOS at most IRFs. However, implementation of the 75% (60%) rule continues to be a major threat, and additionally stringent retrospective audits by Recovery Audit Contractions (RAC) to determine "medical necessity" for IRF admissions have already created great hardships for many IRFs.

How does research affect the future of academic PM&R? It is possible to answer this question in several ways. First, any medical specialty which is not based on a strong scientific foundation will face a difficult future. We must have evidence for the efficacy of our interventions, evidence developed by research experiments which are repeatable by other investigators and consistently yield the same results.

Second, as a clinical specialty, we owe it to our patients to conduct research to improve the treatments we offer. Research helps us to stay on the

cutting edge as clinicians. By conducting research, we offer hope to our patients and show them that we do not accept their impairment, disability and pain. Indeed, we believe that we can improve their condition and their function with new and improved interventions.

Third, a successful research program enhances the reputation of any academic department and along with it the reputation of the entire academic institution, locally, nationally and internationally. Most PM&R departments that are ranked by *US News and World Report* as top rehabilitation facilities have strong, well funded and highly visible research components. Without a strong research component, an academic enterprise will not gain much respect among peers.

A fourth reason to build a research program is to successfully develop new academic leaders. There is no fast method to create academic leaders. They develop in an environment that provides mentoring, participation in research, duty to teach, growing administrative responsibilities, opportunities to present scholarly products and so on. The old phrase "publish or perish" is still a motto for most academic institutions, *i.e.*, no publications, no promotions for faculty members. In very general terms, a publication is preceded by developing a research plan, completing a pilot study, obtaining funding, collecting and analyzing data and presenting research findings in different fora. Not all aspiring academic leaders are willing to accept the hardship of a research career, even when mixed with other responsibilities. Despite lower income compared to procedural oriented physiatrists, academic PM&R is fortunate to have a number of brilliant young physicians who have chosen a career in research for a variety of reasons. These academic physiatrists must be nurtured and supported as much as

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## WASHINGTON UPDATE

## AAP GOVERNMENT RELATIONS REPORT

Prepared by: Peter W. Thomas, J.D. and Padma B. Shah, J.D.  
—Powers, Pyles, Sutter and Verville, P.C.

## “Crossing the Quality Chasm” through the Affordable Care Act

Almost a decade ago, the Institute of Medicine’s Committee on the Quality of Health Care in America released its seminal report *Crossing the Quality Chasm*. The Committee pulled no punches when it stated, “Americans should be able to count on receiving care that meets their needs and is based on the best scientific knowledge. Yet there is strong evidence that this frequently is not the case... Quality problems are everywhere, affecting many patients. Between the health care we have and the care we could have lies not just a gap, but a chasm.”<sup>1</sup> In order to cross the chasm, the Committee urged national leadership and specific actions concerning six domains of quality: safety; effectiveness; patient-centeredness; timeliness; efficiency; and equity.

The Patient Protection and Affordable Care Act (“ACA”), the new health-care reform law, has enormous potential for improving the quality of health care in the United States. Throughout the new law, there are numerous quality provisions of interest to the Association of Academic Physiologists. Some quality provisions relate to the design of an overall national strategy that is inclusive of injury, disability and chronic illness, whereas others specifically relate to each of the six domains noted above. This article provides a brief survey of notable quality provisions.

### National Strategy

The Secretary of Health and Human Services (HHS) is required to establish, through a transparent collaborative process, a national strategy to

improve the delivery of health-care services, patient-health outcomes, and population health. In establishing the national strategy, the Secretary is to identify national priorities and develop a plan for achieving those priorities.<sup>2</sup> An Interagency Working Group, convened by the President, is tasked with developing quality initiatives consistent with the national strategy.<sup>3</sup>

The Affordable Care Act also authorizes the development of quality measures consistent with the national strategy.<sup>4</sup> Specifically, the HHS Secretary, in consultation with the Agency for Health Care Research and Quality (AHRQ) and the Centers for Medicare and Medicaid Services (CMS), is to identify gaps in quality measures and the need for improving existing measures. Similarly, a consensus-based entity, *e.g.*, the National Quality Forum, is tasked with facilitating the endorsement and use of quality measures.<sup>5</sup>

AHRQ’s Center for Quality Improvement and Patient Safety is responsible for supporting health-care delivery-system research in a variety of disciplines. The Affordable Care Act authorizes additions to the Center’s grant capacity to identify, develop, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health-care services.<sup>6</sup>

### Safety

As one commentator has noted, “safety” means that “[p]atients ought to be as safe in health-care facilities as they are in their own homes.”<sup>7</sup> The Affordable Care Act contains several provisions that seek to reduce medical



errors, preventable hospital admissions and readmissions, and health-care-acquired infections. For example, the Affordable Care Act now prohibits Medicaid payments for services related to a health-care-acquired condition, thus complementing similar provisions under the Medicare program.<sup>8</sup> Moreover, under Medicare, a penalty will be assessed on hospitals with a relatively high rate of hospital-based infections.<sup>9</sup> Similarly, under another Medicare provision, hospital payments will be negatively adjusted based on the percentage of preventable readmissions for acute myocardial infarction, heart failure, and pneumonia.<sup>10</sup> Thus, the Affordable Care Act discourages negligent care and inappropriately early discharges that result in unnecessary complications and additional patient services.

### Effectiveness

The purpose of the “effectiveness” prong of the quality agenda is to design a health-care system that matches “care to science, avoiding both overuse of ineffective care and underuse of effective care.”<sup>11</sup> One provision of the Affordable Care Act establishes a Patient-Centered Outcomes Research Institute, an independent, non-profit entity.<sup>12</sup> The purpose of the Institute is to assist stakeholders in making informed health decisions by advancing evidence concerning the manner in which health conditions can be effectively and appropriately prevented, diagnosed, treated, monitored and managed. The Institute must ensure that subpopulations, including the subpopulation of

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people with disabilities, are appropriately accounted for in research designs. In response to concerns about rationing of health care, the Affordable Care Act provides patient safeguards that will prohibit the Institute's findings from being construed as mandated coverage decisions. Thus, the Affordable Care Act encourages the use of science for evaluating whether patients may or may not benefit from a particular treatment, but affords meaningful safeguards against the inappropriate or misguided use of, for instance, comparative effectiveness research.

### Patient-Centeredness

Patient-centeredness is an approach in health care that “honor[s] the individual patient, respecting the patient’s choices, culture, social context, and specific needs.”<sup>13</sup> Some provisions of the Affordable Care Act have been labeled as a “Patient’s Bill of Rights,” picking up the moniker of the legislative effort in the early part of this decade that was ultimately unsuccessful. For instance, one provision requires health plans that use a provider network to let enrollees choose their own primary care provider or pediatrician, in the case of children.<sup>14</sup> Another provision of the Affordable Care Act establishes a program for the development of educational tools, which would allow patients, caregivers, and authorized representatives to better understand treatment options.<sup>15</sup> Another provision concerns patient navigator services, which would help patients overcome barriers to health services and negotiate an often complex and confusing system.<sup>16</sup> The provision reauthorizes demonstration programs, which are evaluating patient navigator services, for FY 2011–2015. Thus, the Affordable Care Act helps promote patient choice and empowerment in clinical care.

### Timeliness

Timeliness seeks to “continually reduce waiting times and delays for

both patients and those who give care.”<sup>17</sup> One provision of the Affordable Care Act prohibits health plans from requiring prior authorizations for emergency services as well as obstetrical or gynecological care.<sup>18</sup> Moreover, with regard to emergency care, a health plan may not increase cost-sharing if the care is rendered out-of-network. Another provision of the Affordable Care Act prohibits group health plans from applying any waiting period exceeding 90 days.<sup>19</sup>

*The Patient Protection and Affordable Care Act (“ACA”), the new health-care reform law, has enormous potential for improving the quality of health care in the United States.*

Thus, the Affordable Care Act protects patients from undue delay in receiving care, but an important shortcoming of the law exists that impacts the provision of specialty services such as physical medicine and rehabilitation. Earlier versions of the Patients’ Bill of Rights legislation in the early 2000’s included provisions for access to specialty care, with the ability of a person with a disability or chronic condition to choose a specialist as a primary care case manager. Unfortunately, these provisions were not included in the Affordable Care Act and will have to be added through the regulatory process if they are to become effective.

### Efficiency

The purpose of the “efficiency” prong of the quality agenda is to reduce “waste, and thereby, the reduction of the total cost of care.”<sup>20</sup> One provision of the Affordable Care Act establishes the Center for Medicare & Medicaid Innovation to develop payment and delivery arrangements to improve the quality and reduce the cost of care.<sup>21</sup> A major thrust of the Accountable Care Act is to focus efforts on high cost patients in order to fairly easily identify and address wasteful, uncoordinated care. Another provision rewards Accountable Care Organizations that meet quality-of-care targets and reduce

costs with a share of the savings they achieve for the Medicare program.<sup>22</sup> Still another provision directs the HHS Secretary to develop a national, voluntary bundled payment pilot for hospitals, doctors, and post-acute care providers.<sup>23</sup> The pilot could be expanded if found to improve quality and reduce costs. Thus, the Affordable Care Act promotes the development of innovative patient care models, including care coordination among providers.

### Equity

Under the principle of equity, patients should not experience variations in care quality resulting from factors such as sex, race, or ethnicity. One provision of the Affordable Care Act ensures that any ongoing or new federal health program collect data on health disparities, including by race and ethnicity as well as sex, primary language, and disability status.<sup>24</sup> The collection and analysis of health disparities data, especially with respect to the new “disability” category, is an important step in ensuring equity in the health-care system. Another provision establishes women’s health offices at various agencies.<sup>25</sup> Such investments in administrative infrastructure help ensure that the health-care needs of women, minorities, and now, people with disabilities, are addressed in an equitable manner, thereby increasing the likelihood of equitable care. Thus, the Affordable Care Act strives to correct these important imbalances in the health-care system.

### Conclusion

The Affordable Care Act is rife with opportunity for transformation of our health-care system. Over the coming years, as health-care reform is implemented, the likelihood that the

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quality of care will significantly improve is fairly high. If many of the new authorizations and programs in the Affordable Care Act meet the promise with which they were enacted, the health-care delivery system is likely to become safer, more effective, more patient-centered, timelier, more efficient, and more equitable. Notably, Dr. Don Berwick was a key member of the IOM Committee that drafted *Crossing the Quality Chasm*. He has now been nominated to serve as CMS Administrator and is pending confirmation in the Senate at the time of this writing. If the Senate confirms his nomination, he will play a pivotal role in

implementing the Affordable Care Act, presumably in a manner that begins to fill the chasm of quality care in the American health-care delivery system.

Resources:

1. Institute of Medicine, Committee on Health Care in America, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington: National Academy Press, 2001).
2. Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, §3011 (2010).
3. PPACA, §3012.
4. PPACA, §3013.
5. PPACA, §3014.
6. PPACA, §3501.
7. D.M. Berwick, "A User's Guide to the IOM's 'Quality Chasm' Report," *Health Affairs* 21, no. 3 (2002): 80-90.
8. PPACA, §2702.
9. PPACA, §3008.
10. PPACA, §3025.
11. Berwick, supra note 7.
12. PPACA, §6301.
13. Berwick, supra note 7.
14. PPACA, §1001, adding §2719A to the Public Health Service Act (PHSA).
15. PPACA, §3506.
16. PPACA, §3510.
17. Berwick, supra note 7.
18. PPACA, §1001, adding §2719A to the PHSA.
19. PPACA, §1201, adding §2708 to the PHSA.
20. Berwick, supra note 7.
21. PPACA, §3021.
22. PPACA, §3022.
23. PPACA, §3023.
24. PPACA, §4302.
25. PPACA, §3059.

## Presidents's Letter (Continued from page 2)

our field is able to. They need to be encouraged and assured that funded grant applications can be used to supplement and even raise their salaries.

Finally, recognizing the importance of research for the future of academic PM&R, it is essential to have access to funding which needs to be both internal and external. An academic PM&R department must have financial reserves, preferably in form of endowments, to support the infrastructure of a research program, seed pilot studies, cover gaps, when external funding is insufficient, etc. The bulk of research funding must come from external sources, preferably from the federal government, which pays substantial overhead to the medical school. In the field of PM&R, grants from the National Institute of Health (NIH) pay significantly higher overhead than grants from National Institute of Disability and Rehabilitation Research (NIDRR) and the Department of Veterans Affairs (DVA). Grants with full overhead will impress the Dean, who needs the money to run the medical school. Internally funded research, which relies on endowments, philanthropy or departmental funds, pays no overhead and does little to please the Dean. In order to strengthen the standing of a PM&R department within the medical school, externally funded research grants with full overhead are essential.

It is unfortunate that federal funding for PM&R research is insufficient and has been essentially flat for many years. Within the NIH, medical rehabilitation research does not have its own institute, but exists as a center (NCMRR) within the National Institute of Child Health and Human Development (NICHD). In my opinion, this is a rather poor fit and in the view of the Disability and Rehabilitation Research Coalition (of

which AAP is a member), there is a need to elevate NCMRR to an independent status, which presumably would increase the responsiveness of our research to the clinical needs of our patients, permit better planning, prioritization, coordination and collaboration of research across NIH, enhance our influence within NIH and, hopefully, result in increased funding of PM&R research. Similarly, NIDRR has at times seemed to fit poorly within the US Department of Education. NIDRR funding has been flat for a decade and applications for "Health and Function" related research must compete with funding for "Employment" and "Community Participation", the other main domains of NIDRR. For the future of academic PM&R, it is vital to strengthen NIDRR with a politically appointed director, indicating a high priority within the Department, research friendly long range plans, strong infrastructure and doubling of its budget over the next five years. In securing funding for PM&R research, physiatrists should not overlook other potential resources, including private foundations, Center for Disease Control, Department of Defense, and for those working at VA Hospitals, the DVA Rehabilitation Research and Development Service.

Of course, the future of academic PM&R depends very much on the recruitment of top medical students to this field, after which we must provide them with the best education and training possible and ultimately we must recruit the best graduating residents for academic positions. Space does not allow me to discuss strategies to accomplish such goals in this President's letter.

*Kristjan T. Ragnarsson, MD*  
President ■

## ACADEMIC AFFAIRS

**2010 ANNUAL MEETING REVIEW**

By Bernadette M. Rensing, Communications Manager

**Overview**

The 2010 Annual Meeting of the Association of Academic Physiatrists (AAP) took place at the Hyatt Regency Coconut Point Resort & Spa in Bonita Springs, Florida, April 6–10, 2010. More than 600 PM&R residents, clinicians, researchers, medical school faculty, department chairs, and medical students from across the United States attended the meeting, making this the AAP's biggest meeting to date.

The 2010 AAP Annual Meeting provided a rigorous educational program that covered an extensive array of research, technology, ideas and viewpoints in its three courses and various council meetings and workshops. Darryl L. Kaelin, MD and his program committee are to be commended for their hard work and the outstanding speakers they made available to the attendees. In addition, the attendees had the opportunity to enjoy the resort amenities of sun, sand and water and spend time networking and sharing concerns, ideas and insights with like-minded, dedicated academicians.

Twenty-eight exhibit booths provided opportunity for interaction with business partners who provided valuable information, demonstrated product benefits and answered questions from attendees during the ample designated exhibitor hours. In the Exhibit Hall, attendees could also find Poster Presentations where more than 340 residents/fellows and clinicians illustrated and revealed their most recent research endeavors and findings.

The meeting began with Kristjan T. Ragnarsson, MD, President of the AAP, who welcomed attendees to Bonita Springs. Dr. Ragnarsson enthusiastically introduced a few upcoming highlights of the event including the Awards

Ceremonies, RMSTP Paper Presentations and the 2011 DeLisa Lecturer, President and CEO of the AAMC, Darrell G. Kirch, MD. Dr. Kirch electrified the crowd with his unique and extremely relevant presentation, *Medical Educators and Physiatrists Venturing into the New World of "Reformed" Health Care*. Dr. Kirch's speech solicited passionate and almost unanimous accolade from the many gracious attendees. The following day, Michael McGeary, Senior Program Officer of the Institute of Medicine, gave the Erdman Lecture, *Advancing Disability Concepts and Public Policies and Programs: IOM Studies of Disability*, which was also very much appreciated by the audience.

Aside from the highly praised plenary session and main courses, other high points of the event included the Residency and Fellowship Program Directors' Workshop, Program Coordinator's Workshop, and PAL program, where participants of each readily noted their tremendous educational value. The Residents and Fellows Dinner was another hit, where—rather than educational value—fun, volleyball and dancing were cited.

**Evaluations**

The AAP used a new, comprehensive, annual meeting data-collection and evaluation form for the first time at the 2010 AAP Annual Meeting in Bonita Springs. The form assesses "impact" of each course and program by requesting the participant to rate the following areas on a scale from "Strongly Agree" to "Strongly Disagree": acquisition of new knowledge; confirmation of the effectiveness of previous skills; inquires about the learning of new techniques, skills, and diagnostic strategies; and the learning of new patient and family com-

munication skills. The form solicits a listing of additional new skills and competencies learned. Additionally, usage areas of new skills and competencies are sampled: provision of patient care; patient and family communications; teaching and educational duties; administrative duties; research endeavors; and team and co-worker interactions.

The form then assesses the "delivery" of each course and program by asking participants to rate the following statements on a scale of "Strongly Agree" to "Strongly Disagree": the course objectives were met; the faculty presented the material well; there was sufficient opportunity to ask questions; the course was free of industry bias; and overall, the course met my expectations. Additionally, the participant is asked "How much of the content was new to you?" and finally, space is provided for individual comments and suggestions for improvement.

**Participant Feedback—  
Main Courses****Overall**

The 2010 Annual Meeting received an overall 93.4% rating of Good (49.0%) to Excellent (44.4%). Only 9 (6.0%) of participants rated the meeting Fair and just 1 (.07%) rated the meeting Poor. Educational Sessions (98.8%) and Networking (95.7%) were the two most important reasons for attending, although the beautiful location (66.9%) certainly didn't hurt. (See Figure 1, Box 1 on next page.)

While all of the educational features of the Annual Meeting were greatly appreciated by the attendees, the Workshops received the highest praise with a 96.6% Good (56.7%) to Excellent

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**Annual Meeting 2010 - Overall Evaluation**

| Indicate how important each of the following was in your decision to attend this year's meeting |                |                    |               |                |
|---|----------------|--------------------|---------------|----------------|
|   | Very Important | Somewhat Important | Not Important | Response Count |
| Educational Sessions  | 68.8% (110)    | 30.0% (48)         | 1.3% (2)      | 160            |
| Networking  | 67.3% (109)    | 28.4% (46)         | 4.3% (7)      | 162            |
| Career Opportunities  | 17.2% (26)     | 32.5% (49)         | 50.3% (76)    | 151            |
| Committees & Council Responsibilities   | 30.9% (46)     | 26.8% (40)         | 42.3% (63)    | 149            |
| Meeting Destination: Bonita Springs, Florida  | 26.9% (43)     | 40.0% (64)         | 33.1% (53)    | 160            |
| <i>answered question</i>  |                |                    |               | 164            |
| <i>skipped question</i>   |                |                    |               | 0              |

Figure 1, Box 1

**Annual Meeting 2010 - Overall Evaluation**

| Meeting Logistics Overall, rate the following features of the Annual Meeting |            |            |           |          |                |
|--|------------|------------|-----------|----------|----------------|
|  | Excellent  | Good       | Fair      | Poor     | Response Count |
| Courses  | 44.2% (68) | 46.8% (72) | 8.4% (13) | 0.6% (1) | 154            |
| Council Programs   | 36.5% (38) | 56.7% (59) | 6.7% (7)  | 0.0% (0) | 104            |
| Workshops  | 42.7% (38) | 53.9% (48) | 3.4% (3)  | 0.0% (0) | 89             |
| Plenary Sessions   | 36.8% (49) | 53.4% (71) | 9.8% (13) | 0.0% (0) | 133            |
| Paper Presentations  | 33.9% (42) | 58.9% (73) | 7.3% (9)  | 0.0% (0) | 124            |
| Poster Grand Rounds  | 28.1% (34) | 62.0% (75) | 9.1% (11) | 0.8% (1) | 121            |
| <i>answered question</i>   |            |            |           |          | 160            |
| <i>skipped question</i>  |            |            |           |          | 4              |

Figure 1, Box 2

**Annual Meeting 2010 - Overall Evaluation**

| Rate the following logistical components |             |            |            |          |                |
|--|-------------|------------|------------|----------|----------------|
|  | Excellent   | Good       | Fair       | Poor     | Response Count |
| Location: Hyatt Regency Coconut Point    | 51.6% (79)  | 35.9% (55) | 11.1% (17) | 1.3% (2) | 153            |
| Hotel Facility                           | 63.3% (100) | 28.5% (45) | 6.3% (10)  | 1.9% (3) | 158            |
| Pre-Registration                         | 73.0% (111) | 24.3% (37) | 2.0% (3)   | 0.7% (1) | 152            |
| On-Site Registration                     | 66.7% (64)  | 32.3% (31) | 1.0% (1)   | 0.0% (0) | 96             |
| Hours of Conference                      | 47.9% (78)  | 47.2% (77) | 3.7% (6)   | 1.2% (2) | 163            |
| Meals / Refreshments                     | 39.4% (63)  | 40.6% (65) | 17.5% (28) | 2.5% (4) | 160            |
| AAP Staff                                | 72.0% (108) | 24.7% (37) | 3.3% (5)   | 0.0% (0) | 150            |
| <i>answered question</i>                 |             |            |            |          | 164            |
| <i>skipped question</i>                  |             |            |            |          | 0              |

Figure 1, Box 3

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(42.7%) rating. See Figure 1, Box 2.

The majority of participants rated almost every logistical component Excellent with the exception of Meals/Refreshments, which was rated Good. See Figure 1, Box 3.

Areas for improvement included accessibility to poster presentations, communication of schedule changes and allotted leisure time.

**Course A—The Changing Face of Academic Practice**

Upon completion of this activity, participants will be able to:

1. Identify key professional characteristics and describe the roles of psychiatrists who have succeeded in leadership positions that transcend the realm of psychiatric departmental leadership.
2. Describe strategies useful for achieving financial success of an academic PM&R department in the new decade.
3. Identify measures of quality utilized in modern psychiatry and medicine and discuss their relative utility for an academic psychiatry practice.
4. Describe strategies to improve psychiatric education at the level of the medical student, PM&R residents, and the practicing psychiatrist.

**Feedback**

- 89.2% of Course A participants Agreed (50.6%) or Strongly Agreed (38.6%) that they acquired new knowledge that will help in the performance of job duties. See Figure 2, Box 1 on next page.
- New skills listed beyond those described in the evaluation tool (Figure 2, Box 2) included: political skills; leadership; communication; faculty and department development; knowledge of disability; faculty recruitment strategies; evaluation feedback, and, an understanding of payment/reimbursement including RVU payments, GME payments, and incentives.

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Annual Meeting 2010 - Course A

| Please select the choice that best describes your answer.         |                |            |            |          |                   |                |                |
|---|----------------|------------|------------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree      | Neutral    | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties  | 38.6% (32)     | 50.6% (42) | 9.6% (8)   | 1.2% (1) | 0.0% (0)          | 0.0% (0)       | 83             |
| I confirmed effectiveness of previous skills                      | 30.1% (25)     | 53.0% (44) | 13.3% (11) | 0.0% (0) | 0.0% (0)          | 3.6% (3)       | 83             |
| I learned new techniques or skills                                | 22.5% (18)     | 43.8% (35) | 17.5% (14) | 5.0% (4) | 1.3% (1)          | 10.0% (8)      | 80             |
| I learned new diagnostic strategies                               | 11.0% (9)      | 14.6% (12) | 24.4% (20) | 7.3% (6) | 1.2% (1)          | 41.5% (34)     | 82             |
| I learned new techniques for patient and family communication     | 12.2% (10)     | 18.3% (15) | 23.2% (19) | 7.3% (6) | 1.2% (1)          | 37.8% (31)     | 82             |
| I acquired new skills and competencies not listed above           | 15.9% (7)      | 40.9% (18) | 15.9% (7)  | 0.0% (0) | 0.0% (0)          | 27.3% (12)     | 44             |
| Please list acquired new skills and competencies not listed above |                |            |            |          |                   |                | 12             |
| <b>answered question</b>  |                |            |            |          |                   |                | <b>83</b>      |
| <b>skipped question</b>   |                |            |            |          |                   |                | <b>7</b>       |

Figure 2, Box 1

Annual Meeting 2010 - Course A







| These skills will improve my work performance in the following areas (Check all that apply) |   |  | Response Percent | Response Count |
|---|---|--|------------------|----------------|
| Provision of patient care   |   |  | 18.8%            | 15             |
| Communication with patients and families  |  |  | 23.8%            | 19             |
| Teaching and educational tasks  |  |  | 66.3%            | 53             |
| <b>Administrative duties</b>  |  |  | 91.3%            | 73             |
| Research endeavors  |  |  | 33.8%            | 27             |
| Team and co-worker interactions   |  |  | 46.3%            | 37             |
| <b>answered question</b>  |   |  |                  | <b>80</b>      |
| <b>skipped question</b>   |   |  |                  | <b>10</b>      |

Figure 2, Box 2

Annual Meeting 2010 - Course A

| Please select the choice that best describes your answer. |                |            |          |          |                   |                |                |
|---|----------------|------------|----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree      | Neutral  | Disagree | Strongly Disagree | Not Applicable | Response Count |
| The course objectives were met                            | 50.0% (40)     | 47.5% (38) | 2.5% (2) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 80             |
| The faculty presented the material well                   | 48.8% (39)     | 39.0% (31) | 2.5% (2) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 80             |
| There was sufficient opportunity to ask questions         | 53.1% (43)     | 43.2% (35) | 3.7% (3) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 81             |
| The course was free of industry bias                      | 61.7% (50)     | 38.3% (31) | 0.0% (0) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 81             |
| Overall, the course met my expectations                   | 48.1% (39)     | 45.7% (37) | 4.9% (4) | 1.2% (1) | 0.0% (0)          | 0.0% (0)       | 81             |
| <b>answered question</b>                                  |                |            |          |          |                   |                | <b>81</b>      |
| <b>skipped question</b>                                   |                |            |          |          |                   |                | <b>9</b>       |

Figure 2, Box 3

(Continued from page 7)

- 90.5% of participants are Likely (44.6%) or Very Likely (45.9%) to apply the skills obtained from Course A to their practice or academic duties.
- 97.5% of participants Agreed (47.5%) or Strongly Agreed (50.0%) that the course objectives were met: Figure 2, Box 3.
- 64.9% of participants felt that 50% or more of Course A content was new to them.
- 92.6% of participants would recommend this course to colleagues.
- Highly regarded topics included Using RVUs in Psychiatric Practice, Creating the Right Incentives and Implementing and Financing the Educational Mission.

**Course B—Road to Recovery after Combat Polytrauma: Rehabilitation, Reintegration, Rating, and Restitution**

Upon completion of this activity, participants will be able to:

1. Describe the system-based approach to polytrauma rehabilitation.
2. Describe the research and new technologies applicable to polytrauma recovery and rehabilitation.
3. Outline the evidence-based practices utilizing this technology to treat impairments after polytrauma.
4. Formulate strategies to address vocational and community reintegration needs. Understand and apply metrics toward compensation and pensioning (C&P) of our wounded warriors.

**Feedback**

- 90.7% of Course B participants Agreed (40.6%) or Strongly Agreed (46.9%) that the course confirmed effectiveness of previous skills and 87.5% Agreed (40.6%) or Strongly Agreed (46.9%) that new knowledge was acquired that will help in future job performance. Figure 3, Box 1 on next page.
- New competencies cited that were

(Continued on page 9)

**Annual Meeting 2010 - Course B**

| Please select the choice that best describes your answer.         |                |            |           |          |                   |                |                |
|---|----------------|------------|-----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree      | Neutral   | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties  | 46.9% (15)     | 40.6% (13) | 9.4% (3)  | 3.1% (1) | 0.0% (0)          | 0.0% (0)       | 32             |
| I confirmed effectiveness of previous skills                      | 46.9% (15)     | 43.8% (14) | 6.3% (2)  | 3.1% (1) | 0.0% (0)          | 0.0% (0)       | 32             |
| I learned new techniques or skills                                | 33.3% (10)     | 53.3% (16) | 10.0% (3) | 3.3% (1) | 0.0% (0)          | 0.0% (0)       | 30             |
| I learned new diagnostic strategies                               | (11)           | 30.0% (9)  | 23.3% (7) | 3.3% (1) | 0.0% (0)          | 6.7% (2)       | 30             |
| I learned new techniques for patient and family communication     | 32.3% (10)     | 38.7% (12) | 16.1% (5) | 6.5% (2) | 0.0% (0)          | 6.5% (2)       | 31             |
| I acquired new skills and competencies not listed above           | 23.8% (5)      | 28.6% (6)  | 19.0% (4) | 4.8% (1) | 0.0% (0)          | 23.8% (5)      | 21             |
| Please list acquired new skills and competencies not listed above |                |            |           |          |                   |                | 3              |
| <i>answered question</i>  |                |            |           |          |                   |                | 32             |
| <i>skipped question</i>   |                |            |           |          |                   |                | 2              |

Figure 3, Box 1

**Annual Meeting 2010 - Course B**



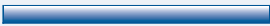



| These skills will improve my work performance in the following areas (Check all that apply) |   |                  |                |
|---|---|------------------|----------------|
|   |   | Response Percent | Response Count |
| Provision of patient care   |   | 66.7%            | 18             |
| Communication with patients and families  |  | 59.3%            | 16             |
| Teaching and educational tasks  |  | 63.0%            | 17             |
| Administrative duties   |  | 51.9%            | 14             |
| Research endeavors  |  | 48.1%            | 13             |
| Team and co-worker interactions   |  | 48.1%            | 13             |
| <i>answered question</i>  |   |                  | 27             |
| <i>skipped question</i>   |   |                  | 7              |

Figure 3, Box 2

**Annual Meeting 2010 - Course B**

| Please select the choice that best describes your answer. |                |            |          |          |                   |                |                |
|---|----------------|------------|----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree      | Neutral  | Disagree | Strongly Disagree | Not Applicable | Response Count |
| The course objectives were met                            | 54.8% (17)     | 41.9% (13) | 0.0% (0) | 3.2% (1) | 0.0% (0)          | 0.0% (0)       | 31             |
| The faculty presented the material well                   | 50.0% (16)     | 46.9% (15) | 3.1% (1) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 32             |
| There was sufficient opportunity to ask questions         | 65.6% (21)     | 31.3% (10) | 3.1% (1) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 32             |
| The course was free of industry bias                      | 62.5% (20)     | 31.3% (10) | 3.1% (1) | 0.0% (0) | 3.1% (1)          | 0.0% (0)       | 32             |
| Overall, the course met my expectations                   | 43.3% (13)     | 50.0% (15) | 3.3% (1) | 3.3% (1) | 0.0% (0)          | 0.0% (0)       | 30             |
| <i>answered question</i>                                  |                |            |          |          |                   |                | 32             |
| <i>skipped question</i>                                   |                |            |          |          |                   |                | 2              |

Figure 3, Box 3

(Continued from page 8)

not listed on the evaluation form (Figure 3, Box 2) included PTSD knowledge; plastics knowledge; increased knowledge of disability; evaluation skills; amputation knowledge; and AMA guidelines.

- 92.8% of participants are Likely (46.4%) or Very Likely (46.4%) to apply the new knowledge and skills learned from Course B to their practice or academic duties.
- 96.9% of participants felt that the material was presented well and 96.7% Agreed (41.9%) or Strongly Agreed (54.8%) that the course objectives were met. See Figure 3, Box 3.
- 72.4% of Course B attendees noted that 50% or more of the content presented was new to them.
- 96.3% would recommend this course to colleagues.
- Highly praised topics included Assistive Technologies and Applications, Incidence, Prevalence and Co-morbidity in the OIF/OEF Service Members and Veterans, and Post-Traumatic Stress Disorder.

**Course C—The Skeletal Muscle Foundation of Movement, Function, and Exercise**

Upon completion of this activity, participants will be able to:

1. Identify competence in muscle physiology and biomechanics.
2. List the role of psychiatry in evaluation and management of skeletal muscle disorders.
3. Primary muscle disorders in neuromuscular disease.
4. Identify the muscle adaptations in healthy states, with exercise, in disease and disuse.

(Continued on page 10)

Annual Meeting 2010 - Course C

| Please select the choice that best describes your answer.        |                |            |            |          |                   |                |                |
|--|----------------|------------|------------|----------|-------------------|----------------|----------------|
|  | Strongly Agree | Agree      | Neutral    | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties | 28.0% (14)     | 60.0% (30) | 10.0% (5)  | 2.0% (1) | 0.0% (0)          | 0.0% (0)       | 50             |
| I confirmed effectiveness of previous skills                     | 30.0% (15)     | 58.0% (29) | 8.0% (4)   | 2.0% (1) | 0.0% (0)          | 2.0% (1)       | 50             |
| I learned new techniques or skills                               | 20.8% (10)     | 56.3% (27) | 16.7% (8)  | 4.2% (2) | 0.0% (0)          | 2.1% (1)       | 48             |
| I learned new diagnostic strategies                              | 14.6% (7)      | 58.3% (28) | 20.8% (10) | 2.1% (1) | 0.0% (0)          | 4.2% (2)       | 48             |
| I learned new techniques for patient and family communication    | 12.8% (6)      | 44.7% (21) | 31.9% (15) | 2.1% (1) | 2.1% (1)          | 6.4% (3)       | 47             |
| I acquired new skills and competencies not listed above          | 14.8% (4)      | 33.3% (9)  | 18.5% (5)  | 3.7% (1) | 0.0% (0)          | 29.6% (8)      | 27             |
| Please list any new skills and competencies not listed above     |                |            |            |          |                   |                | 5              |
| <b>answered question</b>   |                |            |            |          |                   |                | <b>50</b>      |
| <b>skipped question</b>  |                |            |            |          |                   |                | <b>3</b>       |

Figure 4, Box 1

Annual Meeting 2010 - Course C



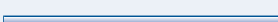


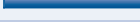
| These skills will improve my work performance in the following areas (Check all that apply) |   |                  |                |
|---|---|------------------|----------------|
|   |   | Response Percent | Response Count |
| Provision of patient care   |    | 81.4%            | 35             |
| Communication with patients and families  |  | 39.5%            | 17             |
| Teaching and educational tasks  |  | 65.1%            | 28             |
| Administrative duties   |  | 34.9%            | 15             |
| Research endeavors  |  | 55.8%            | 24             |
| Team and co-worker interactions   |  | 32.6%            | 14             |
| <b>answered question</b>  |   |                  | <b>43</b>      |
| <b>skipped question</b>   |   |                  | <b>10</b>      |

Figure 4, Box 2

Annual Meeting 2010 - Course C

| Please select the choice that best describes your answer. |                |            |          |          |                   |                |                |
|---|----------------|------------|----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree      | Neutral  | Disagree | Strongly Disagree | Not Applicable | Response Count |
| The course objectives were met                            | 34.0% (17)     | 56.0% (28) | 6.0% (3) | 2.0% (1) | 2.0% (1)          | 0.0% (0)       | 50             |
| The faculty presented the material well                   | 34.0% (17)     | 60.0% (30) | 2.0% (1) | 4.0% (2) | 0.0% (0)          | 0.0% (0)       | 50             |
| There was sufficient opportunity to ask questions         | 48.0% (24)     | 52.0% (26) | 0.0% (0) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 50             |
| The course was free of industry bias                      | 54.0% (27)     | 46.0% (23) | 0.0% (0) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 50             |
| Overall, the course met my expectations                   | 34.0% (17)     | 50.0% (25) | 8.0% (4) | 6.0% (3) | 2.0% (1)          | 0.0% (0)       | 50             |
| <b>answered question</b>                                  |                |            |          |          |                   |                | <b>50</b>      |
| <b>skipped question</b>                                   |                |            |          |          |                   |                | <b>3</b>       |

Figure 4, Box 3

(Continued from page 9)

Feedback

- 88.0% of Course C participants Agreed (60.0%) or Strongly Agreed (28.0%) that new knowledge was acquired throughout this course that will help the performance of their jobs. 88.0% also confirmed the effectiveness of previous skills. See Figure 4, Box 1.
- New techniques or skills listed by attendees that were not included in the evaluation tool (Figure 4, Box 2) included musculoskeletal ultrasound, EMG skills and techniques, physical examination skills, and a new way to select EMG muscles based on a cadaver study by Anthony E. Chiodo, MD.
- 75% of Course C attendees are Likely (47.7%) or Very Likely (27.3%) to apply the new skills and knowledge acquired to their practice or academic duties.
- 94% of participants felt the faculty presented Course C material well and 90% Agreed (56.0%) or Strongly Agreed (34.0%) that the course objectives were met. Figure 4, Box 3
- 58.1% of participants felt that 50% or more of the material presented was new to them.
- 90.2% would recommend this course to colleagues.
- Highly rated topics include Musculoskeletal Ultrasound, Gene Therapy to Improve Muscle Activity in Neuromuscular Disease and Muscle Changes and Adaptations with Aging.

(Continued on page 11)

**Annual Meeting 2010 - Program Coordinators' Preconference Workshop**

| Please select the choice that best describes your answer.         |                |           |           |          |                   |                |                |
|---|----------------|-----------|-----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree     | Neutral   | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties  | 50.0% (5)      | 40.0% (4) | 10.0% (1) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 10             |
| I confirmed effectiveness of previous skills                      | 50.0% (5)      | 40.0% (4) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 10.0% (1)      | 10             |
| I learned new techniques or skills                                | 40.0% (4)      | 40.0% (4) | 20.0% (2) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 10             |
| I learned new diagnostic strategies                               | 40.0% (4)      | 20.0% (2) | 10.0% (1) | 0.0% (0) | 0.0% (0)          | 30.0% (3)      | 10             |
| I learned new techniques for patient and family communication     | 22.2% (2)      | 22.2% (2) | 11.1% (1) | 0.0% (0) | 0.0% (0)          | 44.4% (4)      | 9              |
| I acquired new skills and competencies not listed above           | 33.3% (2)      | 16.7% (1) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 50.0% (3)      | 6              |
| Please list acquired new skills and competencies not listed above |                |           |           |          |                   |                | 0              |
| <b>answered question</b>  |                |           |           |          |                   |                | <b>10</b>      |
| <b>skipped question</b>   |                |           |           |          |                   |                | <b>0</b>       |

Figure 5, Box 1

**Annual Meeting 2010 - Program Coordinators' Preconference Workshop**

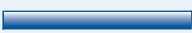




| These skills will improve my work performance in the following areas (Check all that apply) |   |  | Response Percent | Response Count |
|---|---|--|------------------|----------------|
| Provision of patient care   |   |  | 0.0%             | 0              |
| Communication with patients and families  |  |  | 44.4%            | 4              |
| Teaching and educational tasks  |  |  | 66.7%            | 6              |
| <b>Administrative duties</b>  |  |  | <b>88.9%</b>     | <b>8</b>       |
| Research endeavors  |  |  | 22.2%            | 2              |
| Team and co-worker interactions   |  |  | 77.8%            | 7              |
| <b>answered question</b>  |   |  |                  | <b>9</b>       |
| <b>skipped question</b>   |   |  |                  | <b>1</b>       |

Figure 5, Box 2

**Annual Meeting 2010 - Program Coordinators' Workshop**

| Please select the choice that best describes your answer.         |                |            |          |          |                   |                |                |
|---|----------------|------------|----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree      | Neutral  | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties  | 64.0% (16)     | 36.0% (9)  | 0.0% (0) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 25             |
| I confirmed effectiveness of previous skills                      | 56.0% (14)     | 44.0% (11) | 0.0% (0) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 25             |
| I learned new techniques or skills                                | 56.0% (14)     | 24.0% (6)  | 8.0% (2) | 0.0% (0) | 0.0% (0)          | 12.0% (3)      | 25             |
| I learned new diagnostic strategies                               | 45.5% (10)     | 18.2% (4)  | 4.5% (1) | 0.0% (0) | 0.0% (0)          | 31.8% (7)      | 22             |
| I learned new techniques for patient and family communication     | 40.0% (8)      | 15.0% (3)  | 5.0% (1) | 0.0% (0) | 0.0% (0)          | 40.0% (8)      | 20             |
| I acquired new skills and competencies not listed above           | 26.7% (4)      | 26.7% (4)  | 6.7% (1) | 0.0% (0) | 0.0% (0)          | 40.0% (6)      | 15             |
| Please list acquired new skills and competencies not listed above |                |            |          |          |                   |                | 1              |
| <b>answered question</b>  |                |            |          |          |                   |                | <b>25</b>      |
| <b>skipped question</b>   |                |            |          |          |                   |                | <b>0</b>       |

Figure 6, Box 1

(Continued from page 10)

**Participant Feedback— Councils and Workshops**

**Program Coordinators' Preconference Workshop Feedback**

- The Program Coordinators' program began a day early for those that chose to take the TAGME Certification Exam.
- 90% of preconference participants both acquired new knowledge or skills and confirmed the effectiveness of previous knowledge or skills. See Figure 5, Box 1.
- The three highest areas of improved knowledge included Administrative Duties (88.9%), Team and Co-workers Interactions (77.8%) and Teaching and Educational Tasks (66.7%). See Figure 5, Box 2.
- 100% of participants are Likely (60.0%) or Very Likely (40.0%) to apply these new skills to their academic duties.
- 90% of participants felt the course objectives were met and 100% felt the course met expectations.
- 90% would recommend this course to colleagues

**Program Coordinators' Workshop Feedback**

- 100% of participants both acquired new knowledge or skills and confirmed the effectiveness of previous knowledge or skills. See Figure 6, Box 1.
- Administrative Duties (100%) and Team and Co-worker Interactions

(Continued on page 12)

**Annual Meeting 2010 - Program Coordinators' Workshop**

| These skills will improve my work performance in the following areas (Check all that apply) |  |  | Response Percent | Response Count |
|---|--|--|------------------|----------------|
| Provision of patient care   |  |  | 8.7%             | 2              |
| Communication with patients and families  |  |  | 17.4%            | 4              |
| Teaching and educational tasks  |  |  | 69.6%            | 16             |
| <b>Administrative duties</b>  |  |  | <b>100.0%</b>    | <b>23</b>      |
| Research endeavors  |  |  | 8.7%             | 2              |
| Team and co-worker interactions   |  |  | 95.7%            | 22             |
| <i>answered question</i>  |  |  |                  | <b>23</b>      |
| <i>skipped question</i>   |  |  |                  | 2              |

Figure 6, Box 2

(Continued from page 11)

(97.5%) were the two highest rated areas of improved knowledge. See Figure 6, Box 2.

- 100% of workshop participants are Likely (18.2%) or Very Likely (81.8%) to apply these new skills to their job duties.
- 100% would recommend this course to colleagues.

**Chair Council Program Feedback**

- 72.8% of attendees Agreed (27.3%) or Strongly Agreed (45.5%) that new knowledge was acquired that will help perform their job duties. See Figure 7, Box 1.
- Administrative Duties was the highest cited area of knowledge acquired and 80% of participants would recommend this course to colleagues.
- New skills noted that were not included in the evaluation tool (Figure 7, Box 2) included faculty reimbursement models and negotiation.

(Continued on page 13)

**Annual Meeting 2010 - Chair Council Program**

| Please select the choice that best describes your answer.             |                |           |           |           |                   |                |                |
|---|----------------|-----------|-----------|-----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree     | Neutral   | Disagree  | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties      | 45.5% (5)      | 27.3% (3) | 27.3% (3) | 0.0% (0)  | 0.0% (0)          | 0.0% (0)       | 11             |
| previous skills   | 27.3% (3)      | 72.7% (8) | 0.0% (0)  | 0.0% (0)  | 0.0% (0)          | 0.0% (0)       | 11             |
| I learned new techniques or skills                                    | 18.2% (2)      | 36.4% (4) | 36.4% (4) | 0.0% (0)  | 0.0% (0)          | 9.1% (1)       | 11             |
| I learned new diagnostic strategies                                   | 9.1% (1)       | 9.1% (1)  | 9.1% (1)  | 18.2% (2) | 0.0% (0)          | 54.5% (6)      | 11             |
| I learned new techniques for patient and family communication         | 9.1% (1)       | 9.1% (1)  | 0.0% (0)  | 18.2% (2) | 18.2% (2)         | 45.5% (5)      | 11             |
| I acquired new skills and competencies not listed above               | 0.0% (0)       | 50.0% (5) | 40.0% (4) | 0.0% (0)  | 0.0% (0)          | 10.0% (1)      | 10             |
| Please list any acquired new skills and competencies not listed above |                |           |           |           |                   |                | 2              |
| <i>answered question</i>  |                |           |           |           |                   |                | <b>11</b>      |
| <i>skipped question</i>   |                |           |           |           |                   |                | 0              |

Figure 7, Box 1

**Annual Meeting 2010 - Chair Council Program**

| These skills will improve my work performance in the following areas (Check all that apply) |  |  | Response Percent | Response Count |
|---|--|--|------------------|----------------|
| Provision of patient care   |  |  | 18.2%            | 2              |
| Communication with patients and families  |  |  | 9.1%             | 1              |
| Teaching and educational tasks  |  |  | 36.4%            | 4              |
| <b>Administrative duties</b>  |  |  | <b>100.0%</b>    | <b>11</b>      |
| Research endeavors  |  |  | 27.3%            | 3              |
| Team and co-worker interactions   |  |  | 18.2%            | 2              |
| <i>answered question</i>  |  |  |                  | <b>11</b>      |
| <i>skipped question</i>   |  |  |                  | 0              |

Figure 7, Box 2

(Continued from page 12)

**Annual Meeting 2010 - Residency and Fellowship Program Director's Workshop**

| Please select the choice that best describes your answer.         |                  |                   |                  |          |                   |                |                |
|---|------------------|-------------------|------------------|----------|-------------------|----------------|----------------|
|   | Strongly Agree   | Agree             | Neutral          | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties  | 33.3% (9)        | <b>55.6% (15)</b> | 11.1% (3)        | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 27             |
| I confirmed effectiveness of previous skills                      | 40.7% (11)       | <b>44.4% (12)</b> | 14.8% (4)        | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 27             |
| I learned new techniques or skills                                | 33.3% (9)        | <b>48.1% (13)</b> | 14.8% (4)        | 3.7% (1) | 0.0% (0)          | 0.0% (0)       | 27             |
| I learned new diagnostic strategies                               | 15.4% (4)        | 11.5% (3)         | <b>34.6% (9)</b> | 7.7% (2) | 0.0% (0)          | 30.8% (8)      | 26             |
| I learned new techniques for patient and family communication     | <b>34.6% (9)</b> | 19.2% (5)         | 30.8% (8)        | 7.7% (2) | 0.0% (0)          | 7.7% (2)       | 26             |
| I acquired new skills and competencies not listed above           | <b>33.3% (5)</b> | 26.7% (4)         | 20.0% (3)        | 0.0% (0) | 0.0% (0)          | 20.0% (3)      | 15             |
| Please list acquired new skills and competencies not listed above |                  |                   |                  |          |                   |                | 8              |
| <i>answered question</i>  |                  |                   |                  |          |                   |                | <b>27</b>      |

Figure 8, Box 1

**Annual Meeting 2010 - Residency and Fellowship Program Director's Workshop**



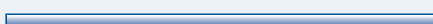



| These skills will improve my work performance in the following areas (Check all that apply) |   |                  |                |
|---|---|------------------|----------------|
|   |   | Response Percent | Response Count |
| Provision of patient care   |    | 30.8%            | 8              |
| Communication with patients and families  |  | 50.0%            | 13             |
| <b>Teaching and educational tasks</b>   |  | <b>100.0%</b>    | <b>26</b>      |
| Administrative duties   |  | 76.9%            | 20             |
| Research endeavors  |  | 7.7%             | 2              |
| Team and co-worker interactions   |  | 84.6%            | 22             |
| <i>answered question</i>  |   |                  | <b>26</b>      |
| <i>skipped question</i>   |   |                  | 1              |

Figure 8, Box 2

**Annual Meeting 2010 - Research Council Program**

| Please select the choice that best describes your answer.        |                  |                   |           |          |                   |                   |                |
|--|------------------|-------------------|-----------|----------|-------------------|-------------------|----------------|
|  | Strongly Agree   | Agree             | Neutral   | Disagree | Strongly Disagree | Not Applicable    | Response Count |
| I acquired new knowledge that will help me perform my job duties | 30.0% (6)        | <b>65.0% (13)</b> | 5.0% (1)  | 0.0% (0) | 0.0% (0)          | 0.0% (0)          | 20             |
| I confirmed effectiveness of previous skills                     | 31.6% (6)        | <b>42.1% (8)</b>  | 10.5% (2) | 0.0% (0) | 0.0% (0)          | 15.8% (3)         | 19             |
| I learned new techniques or skills                               | <b>30.0% (6)</b> | <b>30.0% (6)</b>  | 20.0% (4) | 5.0% (1) | 0.0% (0)          | 15.0% (3)         | 20             |
| I learned new diagnostic strategies                              | 5.0% (1)         | 15.0% (3)         | 10.0% (2) | 5.0% (1) | 5.0% (1)          | <b>60.0% (12)</b> | 20             |
| I learned new techniques for patient and family communication    | 5.0% (1)         | 10.0% (2)         | 10.0% (2) | 5.0% (1) | 5.0% (1)          | <b>65.0% (13)</b> | 20             |
| I acquired new skills and competencies not listed above          | 18.2% (2)        | 27.3% (3)         | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | <b>54.5% (6)</b>  | 11             |
| I acquired new skills and competencies not listed above          |                  |                   |           |          |                   |                   | 5              |
| <i>answered question</i>   |                  |                   |           |          |                   |                   | <b>20</b>      |

Figure 9, Box 1

**Residency and Fellowship Program Directors' Workshop Feedback**

- 88.9% of participants reported that they acquired new knowledge that will help them perform their jobs. See Figure 8, Box 1.
- In addition to the areas listed on the evaluation tool (Figure 8, Box 2), participants specifically highlighted feedback, communication, and leadership skills.
- 100% are Likely (44.4%) or Very Likely (55.5%) to apply the new knowledge to their job duties.
- 100% would recommend this course to colleagues.

**Research Council Program Feedback—Best Practices for Establishing a Psychiatric Research Department in an Academic Medical Center**

- Additional learned new skills and competencies were reported by 60% (Figure 9, Box 1) and included: recognizing reasonable expectations while attempting research in a clinical hospital setting, developing and building a research department, negotiation and organizational skills, and strategic planning.
- The highest cited areas of knowledge acquired were Research Endeavors (94.7%) followed by Administrative Duties (63.2%) See Figure 9, Box 2 on next page.
- 93.8% would recommend this course to colleagues

**Medical Student Clerkship Director's Council Program Feedback**

- 100% of participants acquired new knowledge from this course. See Figure 10, Box 1 on next page.
- 100% of participants cited Teaching and Educational Tasks (80%) and Administrative Duties (60%) as areas

(Continued on page 14)

Annual Meeting 2010 - Research Council Program

| These skills will improve my work performance in the following areas (Check all that apply) |  |  | Response Percent         | Response Count |
|---|--|--|--------------------------|----------------|
| Provision of patient care   |  |  | 5.3%                     | 1              |
| Communication with patients and families  |  |  | 5.3%                     | 1              |
| Teaching and educational tasks  |  |  | 52.6%                    | 10             |
| Administrative duties   |  |  | 63.2%                    | 12             |
| <b>Research endeavors</b>   |  |  | <b>94.7%</b>             | <b>18</b>      |
| Team and co-worker interactions   |  |  | 21.1%                    | 4              |
|   |  |  | <b>answered question</b> | <b>19</b>      |
|   |  |  | <b>skipped question</b>  | <b>1</b>       |

Figure 9, Box 2

Annual Meeting 2010 - Medical Student Clerkship Directors' Council Program

| Please select the choice that best describes your answer.        |                |           |           |          |                   |                |                          |          |
|--|----------------|-----------|-----------|----------|-------------------|----------------|--------------------------|----------|
|  | Strongly Agree | Agree     | Neutral   | Disagree | Strongly Disagree | Not Applicable | Response Count           |          |
| I acquired new knowledge that will help me perform my job duties | 50.0% (3)      | 50.0% (3) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 6                        |          |
| I confirmed effectiveness of previous skills                     | 33.3% (2)      | 50.0% (3) | 16.7% (1) | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 6                        |          |
| I learned new techniques or skills                               | 33.3% (2)      | 33.3% (2) | 16.7% (1) | 0.0% (0) | 0.0% (0)          | 16.7% (1)      | 6                        |          |
| I learned new diagnostic strategies                              | 16.7% (1)      | 16.7% (1) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 66.7% (4)      | 6                        |          |
| I learned new techniques for patient and family communication    | 16.7% (1)      | 16.7% (1) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 66.7% (4)      | 6                        |          |
| I acquired new skills and competencies not listed above          | 0.0% (0)       | 50.0% (1) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 50.0% (1)      | 2                        |          |
| I acquired new skills and competencies not listed above          |                |           |           |          |                   |                | 0                        |          |
|  |                |           |           |          |                   |                | <b>answered question</b> | <b>6</b> |
|  |                |           |           |          |                   |                | <b>skipped question</b>  | <b>1</b> |

Figure 10, Box 1

Annual Meeting 2010 - Medical Student Clerkship Directors' Council Program

| These skills will improve my work performance in the following areas (Check all that apply) |  |  | Response Percent         | Response Count |
|---|--|--|--------------------------|----------------|
| Provision of patient care   |  |  | 0.0%                     | 0              |
| Communication with patients and families  |  |  | 0.0%                     | 0              |
| <b>Teaching and educational tasks</b>   |  |  | <b>80.0%</b>             | <b>4</b>       |
| Administrative duties   |  |  | 60.0%                    | 3              |
| Research endeavors  |  |  | 0.0%                     | 0              |
| Team and co-worker interactions   |  |  | 0.0%                     | 0              |
|   |  |  | <b>answered question</b> | <b>5</b>       |
|   |  |  | <b>skipped question</b>  | <b>2</b>       |

Figure 10, Box 2

(Continued from page 13)

of improved knowledge. See Figure 10, Box 2.

- 100% of participants agreed that the course objectives were met and the course met expectations.

**Program Academic Leadership Program Feedback**

- 100% of participants Agreed (8.3%) or Strongly Agreed (91.7%) that they learned new knowledge that will help them perform their job duties. See Figure 11, Box 1 on next page.
- The three areas participants felt they learned the most about include Administrative Duties (90%), Teaching and Educational Tasks (90%) and Team and Co-worker Interaction (90%). See Figure 11, Box 2 on next page.
- 100% of PAL participants noted that they were Likely (11.1%) or Very Likely (88.9%) to apply the new knowledge learned from this course to their job duties.
- 100% of participants either Agreed or Strongly Agreed that the course objectives were met, the faculty presented the material well, there was sufficient time for questions, the course was industry bias, and that overall, the course met expectations
- 100% of PAL participants felt that at least 50% of the content presented was new to them, with 72.7% agreeing that 75% or more of the content was new to them.
- 100% would recommend this course to a colleague.

- 100% of PAL participants felt that at least 50% of the content presented was new to them, with 72.7% agreeing that 75% or more of the content was new to them.

**Abstracts, Papers, and Posters**

An impressive 344 poster presentations were accepted and displayed at the 2010 Annual Meeting. The best of the poster presentations were showcased as scientific paper presentations (23), Poster Grand Rounds (8), RMSTP Paper Presentations (3) and selected for The Electrode Store Best Paper Awards (4).

(Continued on page 15)

(Continued from page 14)

**Annual Meeting 2010 - Program For Academic Leadership**

| Please select the choice that best describes your answer.         |                |           |           |          |                   |                |                |
|---|----------------|-----------|-----------|----------|-------------------|----------------|----------------|
|   | Strongly Agree | Agree     | Neutral   | Disagree | Strongly Disagree | Not Applicable | Response Count |
| I acquired new knowledge that will help me perform my job duties  | 91.7% (11)     | 8.3% (1)  | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 12             |
| I confirmed effectiveness of previous skills                      | 75.0% (9)      | 25.0% (3) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 12             |
| I learned new techniques or skills                                | 83.3% (10)     | 8.3% (1)  | 8.3% (1)  | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 12             |
| I learned new diagnostic strategies                               | 41.7% (5)      | 8.3% (1)  | 8.3% (1)  | 0.0% (0) | 0.0% (0)          | 41.7% (5)      | 12             |
| I learned new techniques for patient and family communication     | 41.7% (5)      | 0.0% (0)  | 16.7% (2) | 8.3% (1) | 0.0% (0)          | 33.3% (4)      | 12             |
| I acquired new skills and competencies not listed above           | 50.0% (2)      | 50.0% (2) | 0.0% (0)  | 0.0% (0) | 0.0% (0)          | 0.0% (0)       | 4              |
| Please list acquired new skills and competencies not listed above |                |           |           |          |                   |                | 1              |
| <b>answered question</b>  |                |           |           |          |                   |                | <b>12</b>      |

Figure 11, Box 1

**Annual Meeting 2010 - Program For Academic Leadership**

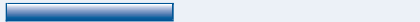
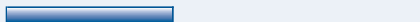



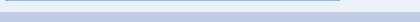
| These skills will improve my work performance in the following areas (Check all that apply) |   |                  |                |
|---|---|------------------|----------------|
|   |   | Response Percent | Response Count |
| Provision of patient care   |    | 40.0%            | 4              |
| Communication with patients and families  |  | 40.0%            | 4              |
| Teaching and educational tasks  |  | 90.0%            | 9              |
| Administrative duties   |  | 90.0%            | 9              |
| Research endeavors  |  | 60.0%            | 6              |
| Team and co-worker interactions   |  | 80.0%            | 8              |
| <b>answered question</b>  |   |                  | <b>10</b>      |
| <b>skipped question</b>   |   |                  | <b>2</b>       |

Figure 11, Box 2

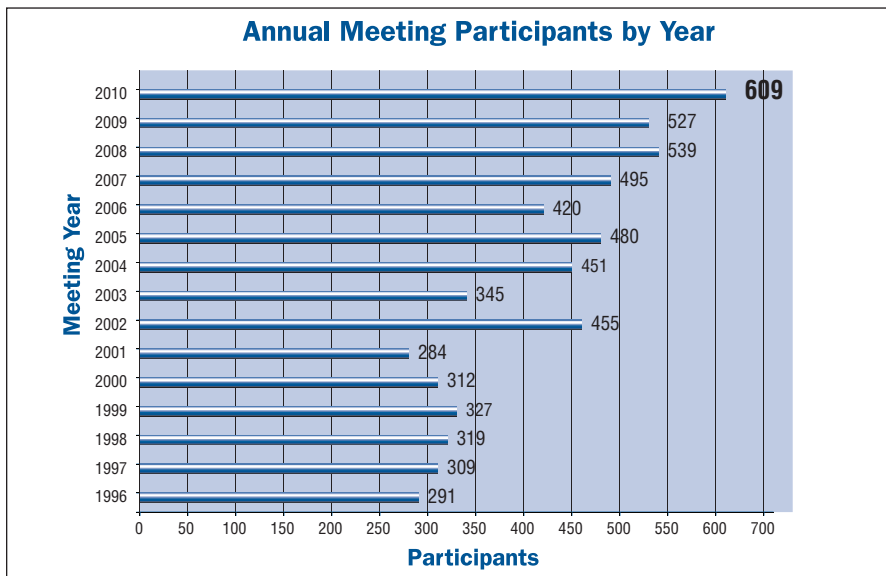


Figure 12

**Meeting Attendance**

The 2010 Annual Meeting was the highest attended meeting in AAP history with 609 participants. See Figure 12.

**Conclusion**

With E-mail, SmartPhones, the Internet and teleconferencing capabilities, technology seems to be relentlessly chipping away at the need for old-fashioned face-to-face meetings. There’s a growing presumption that we can all “meet” virtually with no loss of quality. The AAP Annual Meeting reminds us that there is a tremendous power in offline encounters and that nothing beats networking, socializing and learning with colleagues and friends in person. It’s time to looking forward to the 2011 AAP Annual Meeting in Phoenix, Arizona, April 12–16. See you there!

**Program Committee Members**

- Special thanks to Darryl L. Kaelin, MD and the following AAP Program Committee Members who helped make the 2010 Annual Meeting an outstanding educational development event:
- Thiru Annaswamy, MD, MA, FAAPMR
- Erik S. Brand, MD, MSc
- Brian M. Bruel, MD, MA
- Joseph E. Burris, MD
- Pablo A. Celnik, MD
- Gary P. Chimes, MD, PhD
- Anthony E. Chiodo, MD
- Sara J. Cuccurullo, MD
- Gerard E. Francisco, MD - Board of Trustees’ Liaison
- Kimberly M. Garza
- John S. Harrell, MD
- Henry L. Lew, MD, PhD
- Peter Lim, MD
- Kimberly Middleton, MD - Resident Representative
- Preeti Belliappa Raghavan, MD
- Michael F. Saulino, MD, PhD
- Jeffrey A. Strakowski, MD
- Christopher J. Visco, MD
- Lawrence C. Pencak, MA - CME Director



## The AAP gratefully acknowledges the following exhibitors for supporting the 2010 AAP Annual Meeting:

|   |   |
|---|---|
| AIT Laboratories  | Foundation for Physical Medicine and Rehabilitation |
| Allergan Medical Affairs  | GE Healthcare                                       |
| American Academy of Physical Medicine & Rehabilitation                    | Hocoma, Inc.  |
| American Board of Physical Medicine & Rehab                               | Kessler Institute for Rehabilitation                |
| Aspen Medical Products  | Linear Medical Solutions                            |
| Cadwell Laboratories  | Lippincott Williams & Wilkins-Wolters Kluwer Health |
| Calloway Laboratories   | NIMCO, LLC  |
| Defense and Veterans Brain Injury Center, Walter Reed Army Medical Center | Paralyzed Veterans of America                       |
| Demos Medical Publishing  | Pfizer, Inc.  |
| DMR   | Primal Pictures LTD                                 |
| The Electrode Store   | Primus Pharmaceuticals, Inc.                        |
| Elsevier, Inc.  | Tibion Bionic Technologies                          |
| Faith Medical, Inc.   | Uniform Data System for Medical Rehabilitation      |
| Ferring Pharmaceuticals, Inc.   |   |

## Special thanks go to the following companies for their continued support of an Unrestricted Educational Grant to the AAP:

|  |   |
|--|---|
| Allergan, Inc.   | Resident Dinner   |
| American Board of PM&R Foundation                                      | Program Directors' Workshop   |
| Cadwell Laboratories   | Resident Workshop   |
| The Electrode Store  | Registration Bags, The Electrode Store Best Paper Presentation Awards |
| New York Presbyterian, The University Hospital of Columbia and Cornell | Program for Academic Leadership                                       |
| UT Medical School-Houston  | Lanyards  |
| Wolters Kluwer Health/LWW  | Journal Awards  |

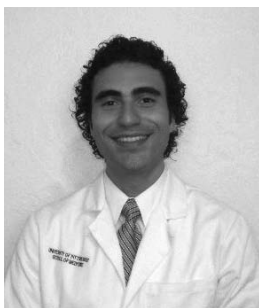
**EDUCATION****2010 RREMS RECIPIENTS ANNOUNCED***By Brad Dicianno, MD, RREMS Director*

The Association of Academic Physiatrists (AAP) and the Foundation for PM&R are excited to announce the results of the third annual Rehabilitation Research Experience for Medical Students (RREMS) grant application cycle. This program allows first year medical students to experience the rewards of scholarly research within the specialty of Physical Medicine & Rehabilitation through an eight-week summer externship.

We received a record number of applications from both site sponsors and students this year. A total of 14 academic institutions applied to host students, generating 17 student applications this year, 14 of which entered the competition, and 3 of which were withdrawn due to early notification that they received funding from NIH T35 training awards. A selection committee of 6 AAP members each scored up to 4 applications each based on scientific merit, research milieu, and dedication of the student. Average scores ranged from 2.5 to 5.0 out of a 1–9 NIH scoring system, with lower scores indicating higher quality. The quality of the applications was tremendous, and several excellent applications fell short of the funding line. However, we were able to fund one additional student this year for a total of 6 slots. The selection committee chose the following students as having the highest quality applications:

**Jordan Silverman**

a student at Boston University School of Medicine, will be mentored by Dr. Leslie Morse at Spaulding Rehabilitation Hospital on the “Assessment of bone marrow hematopoiesis following spinal cord injury in rodents.”

**Christian Agudelo**

from the University of Pittsburgh School of Medicine, will remain at the University of Pittsburgh and study the “Age dependent decline in axonal regeneration after spinal cord injury in zebrafish” under the mentorship of Dr. Martin Oudega.

**Nathan Mohney**

a student at Pennsylvania State University College of Medicine will be mentored by Dr. Amy Wagner on the study “Genetic influences on neuroinflammatory marker profiles and outcome after traumatic brain injury” at the University of Pittsburgh.

**Adele Meron**

from Albany Medical College will be mentored by Dr. Paolo Bonato at Spaulding Rehabilitation Hospital on the study “Robotic gait training with augmented feedback improves motor function in children with spastic cerebral palsy.”

**Wendy Chan**

from the University at Buffalo, School of Medicine and Biomedical Sciences will be mentored by Dr. Brad Dicianno at the University of Pittsburgh on the study “The impact of virtual socialization on individuals with spina bifida.”

**Dara Davenport**

a student at Louisiana State University Health Sciences Center School of Medicine will be working at Mount Sinai School of Medicine under the preceptorship of Dr. Anne Ambrose. Her study is entitled “Assessing gait and balance after traumatic brain injury and impact on at-home patient care.”

Congratulations to the 2010 RREMS Recipients! We will open applications for site sponsors for Summer 2011 projects beginning in Fall, 2010 and will make application instructions available on the AAP website. Please contact Brad Dicianno ([dicianno@pitt.edu](mailto:dicianno@pitt.edu)) with questions. ■

## EDUCATION

### RMSTP NEWS

By Michael Boninger, MD

The RMSTP is happy to welcome 3 new Phase I fellows who are beginning their research training this summer.



#### **James Eckner, MD**

graduated from Case Western Reserve University's School of Medicine in 2003 and completed his residency training in PM&R at the University of Michigan in 2007. Since that time he has held a faculty position in the UM Department of PM&R. As a junior faculty member, he also earned a Master of Science degree in 2009 from the University of Michigan

in Clinical Research Design and Statistical Analysis through the UM On Job-On Campus Master of Science Program. His area of research interest is mild traumatic brain injury (mTBI), with a particular emphasis on mTBI, or concussion, in athletes. He has conducted work under the mentorship of Drs. James Richardson in the Department of PM&R and James Ashton-Miller in the Department of Mechanical Engineering aimed at developing better sideline tests for diagnosing and managing sport-related concussions, specifically through the assessment of reaction time. Dr. Eckner's RMSTP project investigates the role of neck strength and head movement capacity measures in concussion susceptibility through the use of biomechanical modeling techniques. The ultimate goal of this work is to reduce athletes' susceptibility to concussion by developing more effective pre-participation neck strengthening and conditioning programs.



#### **Erik Hoyer, MD**

obtained his medical degree from the Sackler School of Medicine in 2006 after completing both his bachelor's and master's degrees in computer science from Brandeis University. He is currently completing residency training in physical medicine and rehabilitation at Johns Hopkins University and received the outstanding resident award for 2008-9.

As an RMSTP fellow, Dr. Hoyer is interested in studying neuroplasticity of the human motor system. Under the mentorship of Dr. Amy Bastian and Dr. Pablo Celnik, Dr. Hoyer will be exploring bimanual control from both behavioral and neurophysiological perspectives, as well as the application of non-invasive brain stimulation to enhance bimanual task learning.



#### **Brad Kurowski, MD**

completed his BS and MS in biochemistry and molecular biology at the University of Massachusetts, Amherst in 2000. He completed his medical school training at Case Western Reserve University School of Medicine in 2004. Subsequently, he completed his residency at the University of Pittsburgh Medical Center in 2008 and fellowship

training in pediatric rehabilitation medicine at Cincinnati Children's Hospital Medical Center in 2010. During his RMSTP training, he will be studying the relationship of genes and environment to recovery from pediatric traumatic brain injury under the guidance of his primary mentor, Dr. Shari Wade. He will be starting a faculty position at Cincinnati Children's Hospital Medical Center and will hold an academic appointment in the department of PM&R at the University of Cincinnati School of Medicine.

We are happy to welcome our new fellows and look forward to a new set of stimulating topics from the next wave of applicants. ■

**AAP COMMITTEES AND COUNCILS****RESIDENTS/FELLOWS COUNCIL REPORT***By Eric Wisotzky, MD*

One of the main objectives for this year's Residents/Fellows Council (RFC) is to make our specialty, Physical Medicine & Rehabilitation, more recognizable to medical students. We are attempting to accomplish this goal by expanding medical school student interest groups (SIGs) across the country. We are creating a database of medical student interest groups. For some schools without a SIG, we hope to inspire the creation of new SIGs. For example, Dr. Thomas McNalley, at University of Washington, is working

hard to create UW's first PM&R SIG. Later this year, we will publish the first ever PM&R SIG newsletter, to highlight exciting SIG events across the country.

We also hope to increase recruitment of medical students to the 2011 AAP Annual Meeting in Chandler, Arizona. We hope to expand upon the success of this year's medical student program. A new format was used to introduce medical students to PM&R. Skits were used to demonstrate how a physiatrist's unique approach can help patients improve their function and



quality of life. This interactive approach seemed to keep the students interested and prompted a great question and answer session.

Please check the AAP Website ([www.physiatry.org/Education\\_Residents.cfm](http://www.physiatry.org/Education_Residents.cfm)) throughout the year for more details. You can also feel free to post something on the PM&R Resident Forum on the AAP website. If you have any questions, suggestions, comments, or are interested in participating within the AAP, please contact Eric Wisotzky, RFC Chair, at [erw9023@nyp.org](mailto:erw9023@nyp.org). ■

**COORDINATORS' CORNER Summer 2010***By Tammie Wiley-Rice, Daisy Mckenzie and Laura Manore*

Hope you were able to get back to work after the warmth and sunshine in Bonita Springs, Florida. Despite the late date, this year's AAP Conference was a very good one.

**Program Directors Workshop**

We were again invited to attend the Program Directors workshop. It gives us a chance to learn new information together. It also allows us to voice our opinions and concerns, and the directors are right there listening. Being invited to the Program Directors workshop also allows us to interact with our program directors right then, instead of trying to set up a meeting once you are back at work.

**ABPM&R**

Dr. Dennis Matthews gave an update on the ABPM&R. He identified residency training and certification trends, as well as giving the group information regarding the subspecialty certifications available in PM&R for our residents to pursue. The ABPM&R leader-

ship will be changing later this year, and Dr. Matthews updated the group on those changes.

**NRMP**

As always, Dr. Michael Saulino gave a wonderful update on the NRMP. He gave the group information on the changing trends of foreign medical and U.S. medical students applying for residency programs. The group also received information on the changes in the number of programs available. There have been quite a few programs that have either closed or merged with other programs. Dr. Saulino's workshops are always a wonderful benefit!

**ACGME**

Dr. William Bockenek gave the group a review of the roles of the ACGME and RRC. He touched upon the vision and values of the ACGME. Dr. Bockenek mentioned the process of the site visit from the ACGME perspective. The ACGME procedure log topic was discussed at this year's meeting. There

were questions as to whether using the ACGME was a requirement or a choice. Dr. Bockenek informed the group that using the ACGME system was not a choice, but a requirement.

**Other Events for Coordinators****Interview Tips**

Terri did yet another wonderful presentation on interviewing tips. She gave tips on getting faculty and the residents involved. She advised that you make sure you have the room available and dates and times are coordinated with everyone involved. Her most important point was "Don't rank them if you don't want them."

**ABPM&R**

Kevin Randleman did another fantastic presentation this year. The overview of the PD homepage was a good refresher. The forms and information available online will definitely make our jobs less stressful. Just remember to

*(Continued on page 20)*

## Coordinators' Corner

(Continued from page 19)

have all of your information in front of you as you are inputting it into the system.

### Coordinator 102

Kim's presentation was a good source of information. We were able to exchange ideas and pointers that would help with our day to day issues. New coordinators were able to express their concerns, and get needed help. Being able to hear different views and opinions proved to be a benefit to the new and old coordinators alike.

### Coordinator Survivor

Cindy had a fantastic idea when she created this game. The game really showed if you knew your program and common program requirements. It was a definite helper if you were preparing for your site visit at the time of the conference. Cindy had a few trick questions in the game that caught you off guard, even though you just knew you had the right answer.

### The PIF

Miki's presentation on the step-by-step preparation of the PIF has been helping me with my internal reviews and site visits since I started coming to the conference. Her talk is very detailed, and the examples from her very own PIF are the best. She did note that you cannot wait until you are notified of the date of your site visit to start your PIF. Preparation actually begins after your site visit.

### After the Site Visit

New this year, Miki presented her tips for after the site visit. The first tip was to breathe and relax. She gave tips on how to address citations you may receive once the PIF is reviewed. Continue to improve on the program, by creating a written plan of improvement. Monitor the ACGME resident survey. What the residents say on the survey is how they see the program. If it is negative, that has the possibility of coming out during recruitment.

Monitor your duty hours, and review your didactic program. The smallest improvements can benefit your program.

### Conflict Management

Dr. Tracy Johnson's presentation on conflict management was very interesting. Dr. Johnson pointed out how we must work on ourselves before we can work on issues with others. Something within you may be the reason you have conflicts with others. How we relate to others is the key to success at work and in our personal lives as well.

### Generation X and Y

Another new presentation this year was Coretha and Lisa's presentation on Generation X and Y. This presentation touched upon the understanding of the differences between the two. It gave understanding to why there may be frustrations in understanding and dealing with the residents we have.

Overall, this year's AAP Program Coordinator Workshop was informative, the new topics were great additions and more fun than a "work week" should be.

Hope to see you in Phoenix, Arizona next year.

## Dates to Remember

|                |   |
|----------------|---|
| May 26, 2010   | GME Track opened for the 2010 National GME Census (Program Survey only)                       |
| June 30, 2010  | ABPM&R Final Evaluations for the PGY 4's are due to allow them to take their Boards in August |
| July 9, 2010   | Deadline for Program Survey (Freida online listing)   |
| July 14, 2010  | Opening of Resident Survey  |
| Sept. 30, 2010 | Deadline for National GME Census (both Program and Resident Surveys.)                         |
| Sept. 1, 2010  | ERAS opens  |

If you have any questions regarding the AAP Coordinators' Council, please feel free to contact any of the officers:

Chair: Terri Isbell at [terri.isbell@utsouthwestern.edu](mailto:terri.isbell@utsouthwestern.edu)

Chair Elect: Randa Karim at [rkarim@metrohealth.org](mailto:rkarim@metrohealth.org)

Program Directory/Secretary: Kimberly Garza at [GarzaK@uthscsa.edu](mailto:GarzaK@uthscsa.edu)

Immediate Past Chair: Miki DeJean at [miki\\_dejean@emory.org](mailto:miki_dejean@emory.org)

Newsletter Editors: Daisy McKenzie at [mckenzie@bcm.tmc.edu](mailto:mckenzie@bcm.tmc.edu)

Tammie Wiley-Rice at [twileyr@med.umich.edu](mailto:twileyr@med.umich.edu)

Laura Manore at [Laura.Manore@med.va.gov](mailto:Laura.Manore@med.va.gov) ■

## PROGRAM DIRECTORS' CORNER

By Tracy R. Johnson, MD

This quarter's column will be brief: The ACGME has posted the proposed standards for new resident duty hours for review and comment. They are posted on the ACGME homepage, under news. Pay attention to what programs "must do" in terms of resident supervision, resident participation in patient safety and quality improvement initiatives, and new limits on duty hours. Changes could go into effect in July 2011.

Happy summer,  
Tracy

## AAP MEMBER HIGHLIGHTS

### DR. LAWRENCE J. HORN NAMED INTERIM CHAIR

The faculty of the Wayne State University Department of PM&R at the Detroit Medical Center-Rehabilitation Institute of Michigan is very pleased to announce the appointment of Lawrence J. Horn, M.D. as Interim Chair. Dr. Horn has been a Professor in the department for 5 years, having previously been the Chair of the Department of PM&R at the Medical

College of Ohio (now University of Toledo). Dr. Horn's contributions to the field of TBI rehabilitation are well recognized, and he continues to serve as Medical Director for the Southeast Michigan Traumatic Brain Injury Model System.



### DR. ALEX MOROZ TO BECOME RFPD COUNCIL LIAISON TO OPDA



Alex Moroz, MD will be taking over as the RFPD Council Liaison to the Organization of Program Directors Associations (OPDA). The OPDA is a leadership consortium of Residency Program Director Societies in each of the medical and surgical specialties and transitional year programs.

Dr. Moroz is the Director of Residency Training and Medical Education at the Department of

Rehabilitation Medicine, New York University School of Medicine, and Director of Musculoskeletal Rehabilitation Unit at Rusk Institute. Since joining the faculty at New York University, Dr. Moroz has expanded and improved the post-graduate training program for physicians specializing in Rehabilitation and Disability and has received recognition awards for his teaching excellence from the graduating residents in 2001 and 2008. The AAP is grateful to have Dr. Moroz represent the AAP and PM&R among its peer residency associations.

Special thanks to Susan Garstang, MD for her years of contribution to this effort. ■



To have your advertisement or news included in the Fall AAP Newsletter, please submit copy by September 1, to:

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## AAP STAFF HIGHLIGHTS

The AAP is pleased to announce the promotion of Katie Adair to Meetings and Membership Manager. Katie joined the AAP National Office staff in Baltimore, Maryland two years ago, directing member services and Annual Meeting registration.

In this new position, Katie will be in charge of all Annual Meeting responsibilities, in addition to her current duties. She has over 16 years of association and meeting planning experience, including space allocation and set-up; food and beverage, and A/V management; organizing and managing speakers and sessions; exhibitor relations and

exhibitor space planning; and, coordinating meeting travel arrangements.

Katie also brings with her a strong work ethic and an unwavering ability to adapt to new scenarios and challenges as they arise.

The AAP wishes to thank previous Meetings Manager, Lynn Lawson, for her 14 years of dedicated service in ensuring the growth and success of the AAP Annual Meeting.

Vincent A. Fields, Sr., who has served the AAP since 2002, is no longer with the Association and is pursuing other career interests. ■



**CALL FOR PAPERS AND POSTERS**  
**2011 AAP ANNUAL MEETING**  
Sheraton Wild Horse Pass, Chandler, Arizona  
April 12–16, 2011

**ORAL PAPER PRESENTATIONS**

The intent of these oral presentations is to convey the nature of high quality research practice to the meeting participants. These paper presentations will allow researchers to present their theoretical perspectives, the process by which they developed their research questions, the methodology and statistical analysis in detail, and to allow audience members to participate in interactive discussion. Papers for this session should be experimental in nature, and will be chosen not only for their intrinsic scientific merit, but also for their educational value in illustrating the research process.

**DISPLAY POSTERS**

Each poster will be presented in the usual format on 4 x 6 poster board in the exhibit area. The poster presentation is an exhibit providing a forum for a one-to-one, in-depth discussion using narrative and visual material to display and communicate the objectives, methods, results and conclusions of a specific study. Use of visual material such as photographs, charts, and diagrams is very important. The Presenting Author, as the resource person or consultant, should be present at specified times on the days of presentation to engage in discussion with interested individuals.

**Deadline for online submission of all abstracts is 11:59 PM (EST) October 15, 2010.**

**REVIEW PROCESS**

Abstracts prepared according to the instructions and received in the AAP Office by 11:59 p.m. (EST) on October 15, 2010 via online submission at [www.physiatry.org](http://www.physiatry.org), will be independently peer reviewed on a “blind evaluation” (no name) basis. Only the abstract will be available to the reviewers for evaluation to determine merit for presentation. The criteria for reviewing abstracts include: scientific merit, relevance, originality, and clarity. Evidence of completion of the project (*i.e.* specific results data) should be included in the abstract.

The educational value of the proposed abstract and the extent to which it presents new and significant information will be considered. Selections will be made by the AAP Program Committee. All authors will receive electronic notification (e-mail) indicating acceptance or rejection of the abstract submitted. The authors should receive electronic notification (e-mail) by November 26, 2010. Statements made in presentations are the sole responsibility of the authors. Any statement made should not be viewed as, or representative of, any formal stance or position taken on any product, subject, or issue by the AAP.

Authors presenting a paper or a poster **MUST** register for the AAP 2011 Annual Meeting by 11:59 p.m. (EST) February 11, 2011 to display their poster or make a presentation. Registration forms will be published online at [www.physiatry.org](http://www.physiatry.org)

**No requests for refunds from poster and/or paper presenters will be accepted on or after February 12, 2011.**

Questions may be sent to Bernadette Rensing: [BRensing@physiatry.org](mailto:BRensing@physiatry.org)

**CALL FOR PAPERS AND POSTERS****2011 AAP ANNUAL MEETING**

Sheraton Wild Horse Pass, Chandler, Arizona

April 12–16, 2011

**SUBMISSION POLICIES & PROCEDURES**

The Submitting Author must register to submit the abstract online via [www.physiatry.org](http://www.physiatry.org)  
All the other co-authors will be notified of the online abstract submission via e-mail.

The Submitting Author plus every co-author on each abstract must

- 1) register online to participate in the abstract submission process,
- 2) agree to the terms and agreements, including the Disclosure and Copyright Transfer, and
- 3) approve the final abstract.

One of the authors must be identified during the online submission process as the Presenting Author .

Faxes and E-mails containing abstracts and award papers will not be considered.

The number of abstracts to be presented at the 2011 Annual Meeting has been limited to 350.

**ABSTRACT CONTENT**

The abstract must report original material that has not been published or presented elsewhere prior to the 2011 AAP Annual Meeting.

All abstracts submitted for research studies must be structured to summarize the research Objectives, Design, Results and Conclusions. The objectives should contain the background and purpose of the study . The design section should explain key methods, procedures, interventions, and any controls in the study . This allows the reader to infer limitations of the data.

Abstracts containing statements such as “data to be presented” or “the significance of the findings will be discussed” are not acceptable. The conclusions should explain the meaning and importance of the results, and perhaps state any new question identified. Abstracts for Case Reports must be structured in the following four categories: Case Diagnosis, Case Description, Discussion, and Conclusions. Brief Reports and “Other” categories, such as reviews or commentaries, must be submitted in a single paragraph traditional format.

The text in the abstract must be limited to 300 words or less. References, Tables, and Figures may not be included in the abstract submission but may be included in the presentation.

Include no identifying author information, and no mention of any location or institution within the abstract text.

**EVALUATION**

Each abstract will receive a blinded (masked) review by the committee.

The AAP reserves the right to limit the number of abstracts submitted by the same author .

**DEADLINES**

All abstracts must be received via online submission by 11:59 p.m. (EST) October 15, 2010.

Those accepted and rejected will be notified by November 26, 2010.

**One author on each abstract must be identified as the Presenting Author during the online submission process and must register for the 2011 Annual Meeting prior to 11:59 p.m. (EST) on February 11, 2011.**

**PUBLICATION**

Abstracts presented at the AAP Annual Meeting will be published as an online supplement at [www.AJPMR.com](http://www.AJPMR.com)—the official website of the American Journal of Physical Medicine & Rehabilitation. This online version of the Journal is indexed and searchable on Medline and other major medical databases such as OVID.

Failure to comply with the submission policies and procedures will result in the abstract being withdrawn from the meeting and the Journal.

## **THE ELECTRODE STORE BEST PAPER AWARDS**

### **2011 AAP ANNUAL MEETING**

Sheraton Wild Horse Pass, Chandler, Arizona

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The Electrode Store Best Paper Award application must be submitted online at [www.physiatry.org](http://www.physiatry.org) by 11:59 p.m. (EST) on October 15, 2010. Faxes and E-mails containing abstracts and applications will not be considered.

Platform Paper Presentations will include four categories: Medical Student; Resident; Fellow; and Faculty .

Through this effort, the AAP hopes to encourage young researchers and strengthen all investigation in the field of PM&R. These papers will be presented in addition to the other AAP platform papers.

#### **ELIGIBILITY**

Those submitting award papers must be: (1) a medical student mentored by a faculty in a PM&R department; (2) a resident; (3) a fellow in PM&R; (4) a faculty member in PM&R having less than five years post-residency training. The content of the submitted paper must be original research relevant to the domain of PM&R (literature reviews and descriptive case studies are not eligible for these awards). It must have a clearly stated hypotheses, appropriate research methodology and data analysis, and valid conclusions. The investigation in the paper must have been completed prior to the submission.

#### **APPLICATION PROCESS**

To enter the competition for the Electrode Store Best Paper Award, applicants must:

- 1) register and submit a Paper and Poster abstract online via [www.physiatry.org](http://www.physiatry.org).
- 2) Complete the detailed online submission form for the Electrode Store Best Paper Award (including submission of a longer version of the paper limited to 1,000 words).

The longer version of the manuscript must include the following four sections:

**Objective** (background, purpose, hypothesis, and brief literature-based rationale for the study)

**Design** (description, subjects, methods, ethics, interventions, measures, data analysis)

**Results** (primary findings, data presentation, statistical analysis, significance, limitations)

**Conclusions** (importance and implications summarized)

**All materials must be received via online submission by 11:59 p.m. (EST) on October 15, 2010.**

#### **REVIEW PROCESS**

The AAP Program Committee will review the regular Paper and Poster Abstract Application (including short abstracts) independently of the Electrode Store Best Paper Award applications and will make overall decisions about which abstracts merit presentation at the AAP Annual Meeting. Omit identifying information in the text of the abstract or the award paper submission. Avoid any reference to location and/or name of the institution(s) within the text for purposes of blinded (masked) review .

#### **AWARDS**

The winners from each of the categories will be notified via e-mail by December 20, 2010. Winners will be awarded a complimentary AAP Annual Meeting registration and a \$250 monetary award. The winners will be featured during the 2011 AAP Annual Meeting.

**Applications and Abstract Submissions must be completed online at**

**[www.physiatry.org](http://www.physiatry.org)**

**Questions may be sent to Bernadette Rensing: [BRensing@physiatry.org](mailto:BRensing@physiatry.org)**

New from **Oxford**

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Lyn Weiss, Jay Weiss, and Thomas Pobre

Written by leading American practitioners, the *Oxford American Handbooks of Medicine* each offer a pocket-sized overview of an entire specialty, featuring instant access to guidance on the conditions that are most likely to be encountered. Precise and prescriptive, the handbooks offer up-to-date advice on examination, investigations, common procedures, and in-patient care. These books will be invaluable resources for residents and students, as well as a useful reference for practitioners.

The *Oxford American Handbook of Physical Medicine and Rehabilitation* is the essential ready reference guide. The full range of the specialty is covered from managing specific symptoms, injuries and disorders to pediatrics, assistive technology and the psychological and social issues associated with disability. Concisely written and generously illustrated with figures, diagrams and summary tables this is a must-have resource for any clinician in physical medicine and rehabilitation.

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# Pediatric Physiatrist



## Eastern Virginia Medical School

**THE EASTERN VIRGINIA MEDICAL SCHOOL DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION** seeks a double-boarded or fellowship-trained pediatric physiatrist for faculty position. The selected applicant will join two pediatric physiatrists in practice at the Children's Hospital of the Kings Daughters, a full service, free standing pediatric hospital with 180 beds and an 8-bed, inpatient acute rehabilitation unit. Practice includes a busy outpatient practice and participation in multiple subspecialty clinics. Pediatric physiatrists manage a Baclofen Pump Program and Selective Dorsal Rhizotomy Program among other activities.

Eastern Virginia Medical School is the only school of medicine founded by a grassroots effort of the local community. Since the first class matriculated in 1973, the school has graduated more than 2300 physicians, including numerous academic physicians, researchers and practicing clinicians as well as an astronaut. The school's faculty members have received national teaching awards including the Humanism in Medicine award from the AAMC in 2005. The Theresa A. Thomas Clinical Skills Teaching and Assessment Center at EVMS is one of the first and largest of its type and serves as a regional resource for graduate and undergraduate medical students. EVMS students have twice won the AAMC Nickens Award for community service.

EVMS is the largest biomedical research institution in southeastern Virginia and is currently building an \$80 million expansion, including a new building, to provide additional instructional space and an area dedicated to translational research. Medical research at EVMS resulted in the first baby born in the United States by in vitro fertilization. Prostate cancer detection and diabetes management are areas of special expertise and research endeavor at EVMS. The Department of PM&R currently partners with nearby Old Dominion University in research on stroke rehabilitation using virtual reality systems, in addition to other projects.

Norfolk, Virginia is one of seven sister cities in the Tidewater area of Virginia, often referred to as Hampton Roads, with a population base of 1.5 million. Situated on the Chesapeake Bay, Norfolk is 15 minutes from the ocean front of Virginia Beach. Norfolk boasts a fine symphony orchestra, an outstanding opera company, a world class museum, and multiple venues for performing arts. Sports events include the Tidewater Tides baseball team, multiple college level athletic activities, an abundance of water sport opportunities from kayaking to windsurfing, and a regional sports complex for youth and adults in Virginia Beach. In addition to cultural and sports activities, the area's rich history provides wonderful opportunities for study and exploration. An excellent public school system, including public universities, round out the cultural advantages of the area.

Competitive salary and faculty rank commensurate with experience. EVMS is an Affirmative Action/Equal Opportunity Employer and is a Drug & Tobacco Free Workplace. Women and minorities are encouraged to apply.

Interested parties should send curriculum vitae and three letters of reference to Jean E. Shelton, MD at Eastern Virginia Medical School, Department of PM&R, 721 Fairfax Ave, Norfolk, Virginia 23507 or contact her at (757) 446-8496 (office)/(757) 446-5969 (fax), E-mail address: sheltonje@evms.edu.



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Rehabilitation

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Baltimore, MD 21239

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**The Department of Physical Medicine and Rehabilitation of the Johns Hopkins University School of Medicine** is seeking three full-time board-certified / board-qualified physiatrists for our growing department supported by superb staff and facilities.

These extraordinary positions offer ample opportunity for teaching, and clinical practice in a collegial environment of the highest caliber. Clinical and academic track appointments are available. Clinical experience, enthusiasm, strong communication skills, desire for collaboration and a commitment to quality are necessary. Excellence in clinical teaching and the ability to effectively relate to patients and their families is expected.

We offer competitive salary, productivity-based supplement, and outstanding benefits. We are presently recruiting for the following positions:

**1. General PM&R Inpatient Attending**

Located at the Johns Hopkins-affiliated Good Samaritan Hospital Rehabilitation Unit, with additional outpatient practice and EMG opportunities.

**2. Inpatient Consultant Physiatrist**

Located at the Johns Hopkins Hospital; other duties include outpatient clinics with EMG if desired.

**3. Non-operative Spine – Interventional Pain Management**

Located at two Johns Hopkins-affiliated sites. Fellowship in a program that includes training in interventional spine procedures is required. MG skills are welcome.

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**2011**

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## 28 AAP Newsletter ■ Summer 2010

### Program

The U.S. Bone and Joint Decade (USBJD) has a public education program in U.S. communities, in partnership with a number of healthcare professionals and other organizations, including the AAP. This program is offered in response to the Surgeon General's first-ever report in 2004 on bone health and osteoporosis. The program is called "Fit to a T." The T-score is the measure of a person's bone density and susceptibility to fragility fracture.

Educational sessions are being conducted at community public libraries, clinics, health fairs, civic groups, schools and other venues. The one-hour program—aimed at the general public—focuses on bone health, osteoporosis, how to avoid fragility fractures and provide consumers with the information they need to make informed decisions on bone health.

As described below, osteoporosis is a silent disease that drastically alters a person's quality of life and mobility. Its prevalence is escalating, most especially with the aging of the baby-boomer population. At sessions, a medical expert, a health information specialist, and a patient

# Fit to a



team up to present the program. The session features a PowerPoint presentation, live demonstration on health resources through libraries, collateral materials, discussion, question/answer period and follow-up. Hand-outs distributed at sessions include a program booklet, the Surgeon General's brochure, "What it Means to You," and a bibliography.

### Target Audiences

The program targets men and women of all ages, and people who are highly susceptible to osteoporotic fractures or have experienced a break. The goal is to target these individuals before they have a fracture, so they can take necessary steps to prevent bone disease and make changes in their lives to alter the course of the condition. A similar program geared for middle and high school students called PB&J (Protect your Bones and Joints) is also available.

### How to Hold a Session

The U.S. Bone and Joint Decade makes having a Fit-to-a-T session easy! Contact [usbjd@usbjd.org](mailto:usbjd@usbjd.org) or call 847-384-4008. Visit [www.fit2t.org](http://www.fit2t.org) for more information. ■