AAPM&R Leads Effort to Defeat CMS Proposal to Expand NPP Scope of Practice in IRFs

Peter Esselman, MD, FAAPMR
Darryl Kaelin, MD, FAAPMR
Co-Chairs, AAPM&R Future of Inpatient Rehabilitation Workgroup and AAPM&R Past Presidents

We hope our member colleagues already know about the BIG WIN your Academy and Team Physiatry scored on August 4, when the Centers for Medicare and Medicaid Services (CMS) did NOT finalize their proposal, as written, to amend the inpatient rehabilitation facility (IRF) coverage requirements to allow non-physician practitioners (NPPs) to perform certain duties that are currently required to be performed by a rehabilitation physician. Instead, CMS finalized a small piece of the proposal that would have had a detrimental impact on patient care, the specialty, and the future of inpatient rehabilitation.

Why was this policy proposed in the first place? CMS started looking closely at NPP scope of practice expansion in 2018, which AAPM&R opposed. In the 2021 IRF proposal, CMS stated that the goal would be to reduce physician burden and expand access to care, particularly for patients in rural areas.

Our coalition letter adamantly opposed these ideas. Physician burden is not characterized by treating patients, but by administrative and clinically irrelevant paperwork and timelines, which is what your Academy has said in our federal advocacy over the past several years. We again directed CMS to our concerns with physician burden, what causes it, and our proposed solutions. Additionally, we cited data that NPPs are as unlikely to work in rural areas as physicians, making the intended policy goal to expand rural access to IRF care unachievable from this proposal. We also argued that substituting NPPs for rehabilitation physicians would likely cause the quality of care for a highly vulnerable patient population to diminish, resulting in unnecessarily sicker patients and higher Medicare costs. We firmly asserted that the oversight by a rehabilitation physician with specialized training and experience is what differentiates IRF-level care from other post-acute care settings.

Due to our many months of well-reasoned, relentless, and strategically coordinated opposition across rehabilitation and health care stakeholders, CMS decided to take a more prudent and measured approach to expanding NPP scope of practice in IRFs. Effective October 1, 2020, NPPs may now complete one of three weekly face-to-face visits, starting the second week of a patient’s stay, if appropriate under state law.

We are also thrilled to announce CMS’ decision to remove the post-admission physician evaluation (PAPE) documentation requirement, effective October 1, 2020. Your Academy has long advocated to reduce burden for physiatrists by streamlining administrative documentation. CMS’ decision to remove the PAPE is a direct result of our persistent advocacy. As proposed, CMS has also codified into regulation certain elements of the pre-admission screening (PAS); however, they have removed three elements from the Medicare Benefit Policy Manual including expected frequency and duration of treatment in the IRF, any anticipated post-discharge treatments, and other information relevant to the patient’s care needs.

What’s next? We are aware that, even though this is a major win for our specialty, it may open the door to NPP scope of practice expansion in the coming years. We will continue to actively assert our position that physiatry-led, patient-centered, team-based care is the best approach to providing optimized medical rehabilitation care for patients. We are committed to working directly with IRFs and with regulators such as CMS to strengthen the documented definition of rehabilitation physician and to addressing outdated and burdensome regulations in IRFs. We will also continue to rely on all Academy members to support our advocacy efforts so that we have a chance at gaining win after win for physiatry. Congratulations on this major success and thank you to everyone who contributed to the effort! Stay tuned in to AAPM&R for future calls to action.

“It was thrilling to see that 2,377 physiatrists took the time to speak up to CMS about the importance of what we do and to emphasize how critical a PM&R physician is for optimal outcomes for our patients. This win is not just for physiatrists in an IRF; this win is a declaration of the expertise of physiatrists. The Academy was only able to be successful because of the involvement of you, my colleagues, our members. Together, we are extraordinary.”

Michelle Gittler, AAPM&R President

See a full list of our supporters at aapmr.org/IRF2021.

AAMPR’s leadership efforts also resulted in securing bipartisan support from two congressional leaders to oppose the NPP proposal. Read the full article at aapmr.org/IRF2021.
Make Some Noise and Get into “Good Trouble”– Necessary Trouble

Greetings from Chicago, where life is different but nothing is the same. I’m writing this in late July, but you will be reading it in September. The COVID-19 numbers are disturbingly high, and the bars we closed in many states are now open again. Service, the sale of alcohol for carryout or delivery must end at 9 p.m., and the beaches on city lakes are still not open. I hear that the mask mandate is partially right, but what my “mask statement” is Superheroes? Bedazzled? Classic surgical? I would love to hear what your favorite mask looks like. And you, Bedazzled? Classic surgical? I would love to hear what your favorite mask looks like. And you, Bedazzled? Classic surgical? I would love to hear what your favorite mask looks like. And you, Bedazzled? Classic surgical? I would love to hear what your favorite mask looks like. And you, Bedazzled? Classic surgical? I would love to hear what your favorite mask looks like.

Gentrification has stretched down the entire length of my life, but recognizing that my favorite holiday is Passover. Those of you who know me probably know that I was part of the Exodus, a very specific incident in the history of a small Middle Eastern tribe, with the understanding that this is a story of social justice. We tell the story of an oratorio composed mainly of work songs, psalms, and literally hundreds of Matta. What do I mean by Passover. While Passover is a time set aside as a story of justice. We tell the story of the Exodus, a very specific incident in the history of a small Middle Eastern tribe, with the understanding that this is a story of the pursuit of liberation from slavery. In a larger sense, slavery is an exaggerated version of the reality endured by most human beings. The poor accept their fate as destined, the powerful accept good fortune, and the middle class have their day. The most devastating effect of slavery is that it is internalized as an individual’s proper status. This is the reality that was overthrow in the Exodus. As we tell and retell the story of the Exodus, and our ancestors purged from liberation from oppression, we must ask ourselves how we continue to pursue justice in our time. As Elie Wiesel said, “human suffering concerns men and women everywhere. And so, we talk about what we tell our children.” We tell the story of four kinds of children, (really four types of personalities). To the wise or activist child, who asks about how to pursue justice, we say that you must always seek pathways to advocate for the vulnerable. To the skeptical (jeekid) child who wonders they cannot solve the problems, we say that you do not need to solve the problems, you do what you are capable of. But you are not free to remove yourself entirely from the problems. To the indifferent child, who says “it is not my responsibility,” we say the opposite of good is not evil, the opposite of good is indifference. And to the uninformed child, who does not even know how to formulate the question, it is our responsibility to tell the story.

Learning Something New

During this time of year, when we say “goodbye” to our graduating PM&R residents and “welcome” to our incoming interns, I am humbled by how relevant this is for me personally, right now. In the past few weeks the credibility of those statements have been much greater because I must admit to adopting this myself. I am struck by how much I am learning.

As someone who has many friends and colleagues of different ethnicities, races, and backgrounds, who feels comfortable interacting with people of many different orientations, and who considers himself progressive, fair, and decent, I consider that I have done more than enough to be able to improve the world. Turn out that I have been wrong—well, maybe I was partly right. I have learned that being Non-racist is NOT the same as being Antiracist: Being non-racist is necessary but not sufficient. Being non-racist is helpful and beneficial, but what really improves the world is the struggle of a lifetime. Never, said, “do not get lost in a sea of despair. Be hopeful, optimistic. Our struggle is not the struggle of the day, a week, a month, or a year, it is the struggle of a lifetime. Never, ever be afraid to make some noise and get in good trouble.”

I look forward to getting into good trouble, necessary trouble with all of you, as we advocate for access to rehabilitation and the services of physiatrists, as we advocate for our patients who cannot or do not speak up for themselves, and as we continue to advocate for our colleagues who have not felt heard. I hope you and your families stay well. With warm regards, Michael.

We have learned from the president of the American Medical Association that face coverings are a critical tool in the fight against COVID-19 that could reduce the spread of the disease, particularly when used universally. My favorite masks have now stretched out just like my favorite underwear. And whether or not I wear a mask, I have found that being non-racist is NOT the same as being Antiracist. Being non-racist is necessary but not sufficient. Being non-racist is helpful and beneficial, but what really improves the world is the struggle of a lifetime. Never, ever be afraid to make some noise and get in good trouble.

Reactions on Twitter

Lisa Varghese-Kroll, MD, FAAPMR (@LisaVarghese) - Aug 7

This is great news. There is no substitute for the 7-12+ years of training (post-college, no less) of a physician.

Azlan Tariq D.O. FAAPMR (@DrAzlanTariq) - Aug 6

So glad to see the unified voice of 2377 physiatrists can make a difference #Physiatry2020

Ben Miller, MD (@BenMiller_MD) - Aug 5

Proud to be one of the 2377 voices advocating for the future of #Physiatry

Amy J Houtrow, MD, PhD, MPH (@Houtrow) - Aug 4

Great news! Thank you physiatrists everywhere for advocating for our field. #Physiatry

“when everyone has access to the same rights, opportunities, and resources.” Equity involves eliminating of the inequity. How did not understand these distinctions before? And while we’re reviewing definitions, let’s examine “diversity” and “inclusion” (Figure 1) Two things you know for sure: (1) this is a form of racism that is considered, and selectively, and the collective strength of their experiences, beliefs, values, and perspectives. This involves demonstrating respect for the abilities, beliefs, backgrounds, and cultures of those around us and engaged with those with different perspectives. But, while others feel an unconditional sense of belonging for who they are.

All of us in medicine, including those in academic medicine, are aware of disparities in the way people are treated and in the outcomes achieved. Microaggressions and biases exist, and need to be called out. The lack of physicians of color in many institutions and practices, and an obligation to correct and reverse this. This is a form of racism that is considered, and selectively, and the collective strength of their experiences, beliefs, values, and perspectives. This involves demonstrating respect for the abilities, beliefs, backgrounds, and cultures of those around us and engaged with those with different perspectives. But, while others feel an unconditional sense of belonging for who they are.

It is difficult to realize our flaws, and it is uncomfortable to have these hard conversations, but it is only by confronting our shortcomings and inadequacies that we can begin to address and correct them. We may not be able to make sense of the tragedies that have occurred, but we can work to use the present experience as an opportunity and as a starting point for impacting the experiences of patients and patients and to improve outcomes. A短板, we do not improve from our shortcomings and inadequacies, committing to improving our knowledge of racism, and standing up to eliminate overt and implicit racism in our culture and in our everyday interactions. We need to fight not only the discrimination we see in our daily lives, but also the bias that is sometimes more subtle, but is baked into many of the institutions and organizations with which we work. And we need to commit ourselves to learning.

It is gratifying that AAPMR has undertaken several initiatives to address racism. The Diversity & Inclusion Committee is involved with developing, implementing, integrating, and supporting strategies and activities to achieve priority goals related to diversity and inclusion and to creating an equitable and welcoming environment. The Inclusion & Engagement Committee is a new committee focused on developing and fostering the Academy’s goals around the inclusion and engagement of its diverse members. There are Member Community Groups focused on specific groups, such as African American Women, Physician Women, etc.

The AAPMR Board of Governors also recently initiated monthly Critical Conversation Webinars on equity and access across health care. This is a series of thoughtful discussions on racial equity, access, and inclusion in today’s world. The first Critical Conversation Webinar in the series, “Access to PM&R: Health Care, and Society,” was held on July 14, 2020, and hosted by Dr. Gittler, AAPMR President. The webinar report for the AAPMR Board of Governors and others to listen and to understand how racial inequities impacted African-American members of the
Thoughts on the State of our Country, and the Foundation’s Place in It

I spent the first part of July recreating on the wildflower covers of Oregon and Idaho, far off the grid and oblivious to the vicissitudes of daily news, data dumps and video images from the national scene, which was truly a blessed relief. Of course, I had hoped upon my return to civilization that I would find a significant decline in the incidence of COVID-19 infections, a decrease in death rates, and a turn toward more normal hospital functions. Needless to say, my hopes were dashed, smashed and battered like the deer carcasses on the roadside during our drive home.

In a world of opportunities, we seem to have taken wrong choices in many. While medical scientists are tirelessly seeking improvements in treatments, vaccines and medical outcomes, sadly the burden of care expands on what seems a daily basis. Certainly research is being done at heroic levels, but as case counts grow, the responsibilities explode for after-care providers including physicians. Medical professionals, and perhaps especially those of us in the PM&R community throughout their professional journeys. I listened to this meeting with CMS, Dr. Shah contributed to drafting the amendment to the NCD.

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From the editor

#PMRAdvocates: Academy Members Advocating for the Specialty

- Dr. Arjyal Shah (University of Texas Southwestern) acted as a physician expert in a discussion with the Centers for Medicare and Medicaid Services (CMS) regarding amending an existing National Coverage Determination (NCD) for Seat Elevation and Standing-Nature Power Wheelchairs. Prior to this meeting with CMS, Dr. Shah contributed to drafting the amendment to the NCD.

Congratulations to AAPM&R 2020 Award Recipients

AAPM&R announces its distinguished 2020 awards that recognize lifetime achievement, distinguished membership, and pioneering physiatrists, clinicians, researchers, dedicated volunteers, and public servants who have made significant contributions to both the specialty and to people with disabilities. The AAPM&R Awards Committee received yet another round of excellent nominations submitted by Academy members. Recipients of the following awards will be acknowledged during the AAPM&R virtual Annual Assembly at the 52nd Walter J. Zeiter Lecture and Awards Program Video Presentation on Sunday, November 15.

2020 AAPM&R Nominating Committee Report of Elected Positions

The AAPM&R Nominating Committee respectfully submits the following Academy Fellows for election at the Annual Business Meeting to be held virtually on Friday, November 13 from 4 - 5:30 pm. Read more about the candidates on our website.

2020 AAPM&R Nominating Committee Report of Elected Positions

- Peter C. Esselman, MD, FAAPMR
- Darryl L. Kaelin, MD, FAAPMR
- Michelle S. Gittler, MD, FAAPMR
- Brenda S. Waller, MD, FAAPMR
- Arthur J. De Luigi, DO, FAAPMR

The names in blue will appear on the nomination slate for election. The Nominating Committee slate was formally posted on www.aapm.org/businessmeeting in August.

2020 President-Elect Stuart M. Weinstein, MD, FAAPMR, will ascend from President-Elect to President in 2021. 2020 President Debrah A. Venesy, MD, FAAPMR, will automatically ascend to become the 2021 President-Elect.

NOTICE OF AAPM&R ANNUAL BUSINESS MEETING

Date: Friday, November 13, 2020
Time: 4 - 5:30 pm
Academy Fellow members are invited and encouraged to virtually attend AAPM&R’s Annual Business Meeting on Friday, November 13 from 4 - 5:30 pm. Members will vote on nomination recommendations, approve the membership roster, consider a Bylaws amendment to finalize the gender-neutral language of the Bylaws and an amendment to adjust the composition of the Nominating Committee, review 2020 activities, and preview 2021 Academy initiatives.

View the Business Meeting Agenda, Nominating Slate and Proposed Bylaws Amendments at www.aapm.org/businessmeeting. Watch for updates and connection information coming soon.

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- Frank H. Krusen, MD, Lifetime Achievement Award
- 2020 PASSOR Legacy Award and Lectureship
- Distinguished Public Service Award
- Distinguished Member Award
- Distinguished Service Award
- Distinguished Research Award
- Distinguished Public Service Award

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AAPM&R is thrilled to bring the energy, spirit, and collaboration of a face-to-face gathering to the virtual event of the year! We’re transforming #AAPMR20 to offer you a whole new event experience with creative learning opportunities, entertaining networking events, cutting-edge research, and so much more! Our program includes both in-person and virtual presentations, videos, research posters, the popular Job and Fellowship Fair, and more! Attendees will enjoy a virtual learning experience unlike any other.

Education takes center stage at #AAPMR20 and it all starts with our pre-Assembly sessions. Choose from 3 exciting offerings:

**Utilizing Ultrasound in Your PM&R Practice**
- The 2020 AAPM&R virtual ultrasound session will focus on how ultrasound can be utilized to enhance any musculoskeletal or neuromuscular physiatry practice.
- Attendees will learn via interactive case-based scenarios.

**Advancing Clinical Skills in Spasticity Management**
- In this valuable virtual course, you’ll learn how to enhance your clinical skills in managing patients with spasticity and related conditions.
- Attendees will learn via updated journal club round-tables, presented with case-based scenarios, interactive lectures on treatment plans, and observe hands-on skills that are relevant to that case scenario.

**Navigating Opioid Management in a Pandemic**
- The current opioid crisis and pandemic are two intersecting challenges of opioid management.
- Physiatrists are at the forefront of treating acute and chronic pain conditions and are frequently asked to manage pain as a method of improving function.
- Given the current environment and the fluctuating ability to see patients, this pre-course is meant to complement the robust STEP Ultrasound Certificate Program curriculum.
- Partial support for the Utilizing Ultrasound in Your PM&R Practice session has been provided through an educational grant from Allergan, an Abbvie company; Ipsen Biopharmaceuticals, Inc.; Merz North America, Inc.; Saol Therapeutics, in compliance with ACCME Standards for Commercial Support.

Partial support for the Advancing Clinical Skills in Spasticity Management session has been provided through an educational grant from Allergan, an Abbvie company; Ipsen Biopharmaceuticals, Inc.; Merz North America, Inc.; Saol Therapeutics, in compliance with ACCME Standards for Commercial Support.

**MEET TEAM PHYSIATRY’S PLENARY SPEAKERS**

**Presidential Address and Plenary Keynote:**
- Michelle S. Gittler, MD, FAAPMR and Jill Boite Taylor, PhD

**AAPM&R President Michelle S. Gittler, MD, FAAPMR, will officially launch #AAPMR20 and welcome attendees.** Then Dr. Gittler and Jill Boite Taylor, PhD, a Harvard-trained and published neuroanatomist, will participate in a fire-side chat about Dr. Taylor’s inspiring journey.

In 1996, a blood vessel exploded in the left half of her brain. Over the course of 4 hours, Dr. Taylor watched her mind completely deteriorate, until she could not walk, talk, read or recall any of her life. It took 8 years for her to completely recover all function. In 2008, Dr. Taylor gave the first TED talk that ever went viral; she was the premier guest on Oprah’s Soul Series, and she was named one as of Time Magazine’s 100 Most Influential People in the World for 2008. In 2020, Dr. Taylor will publish book #2 about insights into Whole Brain Living, and she is committed to educating the public about neuroplasticity and the ability of the brain to recover from stroke or brain trauma.

Spend part of your morning listening to the outstanding top submissions from our “Call for PhyzTalks.” PhyzTalks are TED™-style talks, which feature stories that are compelling and impactful to physiatrists.

**S2nd Walter J. Zeiter Lecture and Awards Video Presentation:**
- Will Waller

Will Waller is the CEO of the National Wheelchair Basketball Association (NWBA). After a 20-year career in human resources at 3 Global, Fortune 150 companies, he has performed a variety of global business partner roles, as well as led large scale change initiatives.

In 1992, a bullet pierced Will’s spine and kidney in a gang-related shooting. He suffered a mixed conus cauda equina injury to his lower back, which left him with some sensation feeling and slight movement, as well as other functionality. As a result, Will has chronic leg pain, and eventually, his kidney had to be removed. In helping him through his physical and emotional challenges, one of his doctors at the Schwab Rehabilitation Hospital eventually persuaded him to apply to junior college.

He eventually joined the Cleveland Wheelchair Cavaliers and performed at the highest level for team USA, having won 2 Paralympic Bronze Medals and 2 World Championships. The NWBA leadership role has allowed Will to leverage his blend of business and sporting.

Prior to Will’s presentation will be our AAPM&R Awards Video Presentation! Our 2020 award winners will be recognized for their significant contributions to both the specialty and to people with disabilities.

Find more information and register now at [www.aapmr.org/2020](http://www.aapmr.org/2020).
The AAPM&R Clinical Practice Guidelines (CPG) Committee is dedicated to evaluating, endorsing, and advocating for key guidelines that are critical to the field of PM&R. The committee supports efforts to identify physiatrists as external development of clinical guidelines in order to positively impact the specialty and the care PM&R patients receive. To date, the reviews and endorsements from the committee have provided members with a repository of clinical guidelines that are meaningful to the practice of PM&R and have helped identify gaps to inform future guideline development. As the committee continues to evolve, their efforts not only focus on increasing awareness of relevant guidelines, but also help physiatrists understand how to implement the guidelines and recommendations that are most relevant into their daily practices.

AAPM&R, represented by Dr. Matthew Smuck, participated in the development of the North American Spine Society Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain, a critical guideline to the specialty. This comprehensive guideline is intended to provide evidence-based recommendations to assist in delivering optimum, efficacious treatment and functional recovery from nonspecific low back pain. As a key stakeholder, AAPM&R was given the opportunity to review and provide comments on the draft guideline before it was published. The review of the draft guideline was completed by CPG members, Armando S. Mijares, Jr., MD, Chae S. Eun, MD, David W. Lee, MD, K. Rao Pothuri, MD, and Jeffrey Radecki, MD: Clinical Domain Experts (CDEs) from the AAPM&R committees were also consulted to provide comments on the draft and final guideline. David W. Lee, MD, John M. Laseter, MD, MPH, Christopher J. Standert, MD, and Joseph H. Thomas, DO, MBA volunteered to serve as CDE reviewers.

The CPG Committee evaluated the guideline according to the Appraisal of Guidelines for Research and Evaluation (AGREE) II Tool to determine their specific status of “Endorsement.” This tool allows reviewers to assess the methodological rigor and transparency in which a guideline is developed to determine if it does not allow reviewers to assess the content of a guideline. Consequently, the CPG Committee adopted elements of the Guideline Implementing Appraisal Tool (GIAT) to facilitate the CDE assessment of the recommendations included within the NASS guideline. The CDEs used a consistent process to identify six guidelines from the NASS guidelines that were relevant to physiatry, so the review does not constitute the entirety of this guideline. However, the review does include acknowledge additions in the guideline that physiatrists may be interested in reviewing.

The six recommendations each evaluate the factors of 1) Declarability (precisely under which circumstances to do something), 2) Executability (exact what to do under the circumstances defined), 3) Measurability (the degree to which the guideline identifies markers or endpoints to track the effects of implementation of this recommendation), 4) Options of measurement include subjective self-reporting, objective testing, accelerometers, and other counters, etc. If the participant has a wearable tracking device or remote health monitoring system, data could relay criteria listed above to the electronic medical record system. Other objective measures may include the patient’s ability to complete specific exercises, as well as tolerance to certain durations and frequencies of aerobic activity.

Summary of Validity (the degree to which the recommendation reflects the intent of the developer and the strength of evidence): The referenced literature supports exercise as a treatment for low back pain. The recommendation has a broad scope and may be tailored accordingly.

The AAPM&R Clinical Practice Guidelines Committee is committed to providing physiatrists with evidence-based guidelines that are critical to the field of PM&R. The committee’s goal is to continue to evolve and to be refined to provide meaningful digests and implementation guidance for future guidelines relevant to the specialty. Below is an excerpt from the full AAPM&R CPG Commentary. The full commentary can be viewed at: www.aapmr.org/endorsed-guidelines.

Recommendation #1: Aerobic exercise is recommended to improve pain, disability and mental health in patients with nonspecific low back pain at short-term follow-up. Grade of Recommendation: A

Summary of Declarability (precisely under which circumstances to do something): Physiatrists should not encounter difficulty, nor confusion, recommending aerobic exercise as part of treatment program for low back pain. This recommendation applies to low back pain which is considered as a single condition for this recommendation as opposed to other related back conditions. Providers should be able to reasonably identify situations where applicable clinically.

Summary of Executability (exact what to do under the circumstances defined): The detail on the specific type of aerobic exercise is not elaborated. Some studies recommend high intensity aerobic exercises based on heart rate parameters, but this is not a universal recommendation from the guidelines. Therefore, the recommendation to physiatrists is that aerobic exercises are recommended and will most likely encompass numerous types of treatment depending on availability, patient and provider interest and cost. This recommendation, therefore, should be addressed to non-physician providers for interpretation when implementing this clinically.

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Christopher Standert, MD, FAAPMR and Ian Janes, Health Policy and Payment Coordinator

On July 18, 2020, the Innovative Payment and Practice Models Committee (IPPM) held an all-day virtual meeting. IPPM’s virtual meeting agenda provided space for several strategic discussions. These discussions included: Committee members were able to outline priorities and create workgroups within the committee to address these priorities for the rest of 2020 and beyond, by accomplishing the following items:

• Creating a new workgroup that explores the development of a payment model in the stroke space.

• Engaging the spine care workgroup (responsible for recently publishing an article on physiatry’s value within spine care) to advance an alternative spine care model in a collaborative process that aligns with PM&R BOLD.

• Assessing PM&R BOLD’s priorities and how they can be achieved within alternative payment structures.

• Discussing collaboration with the Evidence, Quality, and Performance Committee (EQPC) on exploring the potential development of an alternative model of care and joint efforts on model development.

• Reviewing the alternative payment model related regulatory landscape.

• Discussing next steps for engaging with relevant agencies within CMS.

• Discussing ways to educate members on payment models such as drafting Physiatrist articles and educational resources on alternative payment models.

IPPM plans to connect again later this year, and workgroups within the committee will be expected to provide updates on their projects. Throughout the year, IPPM will continue to publish payment-related articles in The Physiatrist and in the Connection e-newsletter.

Physiatrist: The Practice Guide to Osteoarthritis

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Your Academy Publishes Guideline Commentary for the North American Spine Society (NASS) Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain

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Summary of Measurability (the degree to which the guideline identifies markers or endpoints to track the effects of implementation of this recommendation): Options of measurement include subjective self-reporting, objective testing, accelerometers, and other counters, etc. If the participant has a wearable tracking device or remote health monitoring system, data could relay criteria listed above to the electronic medical record system. Other objective measures may include the patient’s ability to complete specific exercises, as well as tolerance to certain durations and frequencies of aerobic activity.

Summary of Validity (the degree to which the recommendation reflects the intent of the developer and the strength of evidence): The referenced literature supports exercise as a treatment for low back pain. The recommendation has a broad scope and may be tailored accordingly.

Through this process, the CPG Committee and CDEs developed a pilot CPG Commentary for the NASS Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain. This tool allows IPPM to facilitate the CDEs assessment of the recommendations included within the NASS guideline. The committee supports efforts to identify physiatrists as external development of clinical guidelines in order to positively impact the specialty and the care PM&R patients receive. To date, the reviews and endorsements from the committee have provided members with a repository of clinical guidelines that are meaningful to the practice of PM&R and have helped identify gaps to inform future guideline development. As the committee continues to evolve, their efforts not only focus on increasing awareness of relevant guidelines, but also help physiatrists understand how to implement the guidelines and recommendations that are most relevant into their daily practices.

AAPM&R, represented by Dr. Matthew Smuck, participated in the development of the North American Spine Society Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care: Diagnosis and Treatment of Low Back Pain, a critical guideline to the specialty. This comprehensive guideline is intended to provide evidence-based recommendations to assist in delivering optimum, efficacious treatment and functional recovery from nonspecific low back pain. As a key stakeholder, AAPM&R was given the opportunity to review and provide comments on the draft guideline before it was published. The review of the draft guideline was completed by CPG members, Armando S. Mijares, Jr., MD, Chae S. Eun, MD, David W. Lee, MD, K. Rao Pothuri, MD, and Jeffrey Radecki, MD: Clinical Domain Experts (CDEs) from the AAPM&R committees were also consulted to provide comments on the draft and final guideline. David W. Lee, MD, John M. Laseter, MD, MPH, Christopher J. Standert, MD, and Joseph H. Thomas, DO, MBA volunteered to serve as CDE reviewers.

The CPG Committee evaluated the guideline according to the Appraisal of Guidelines for Research and Evaluation (AGREE) II Tool to determine their specific status of “Endorsement.” This tool allows reviewers to assess the methodological rigor and transparency in which a guideline is developed to determine if it does not allow reviewers to assess the content of a guideline. Consequently, the CPG Committee adopted elements of the Guideline Implementing Appraisal Tool (GIAT) to facilitate the CDE assessment of the recommendations included within the NASS guideline. The CDEs used a consistent process to identify six guidelines from the NASS guidelines that were relevant to physiatry, so the review does not constitute the entirety of this guideline. However, the review does include acknowledge additions in the guideline that physiatrists may be interested in reviewing.

The six recommendations each evaluate the factors of 1) Declarability (precisely under what circumstances to do something), 2) Executability (exact what to do under the circumstances defined), 3) Measurability (the degree to which the guideline identifies markers or endpoints to track the effects of implementation of this recommendation), and 4) Validity (the degree to which the recommendation reflects the intent of the developer and the strength of evidence). These factors help describe a recommend, however, it is limited, not applied to practice, noting any barries to translating the evidence into action.
From PM&R Consults and EMGs to Treating COVID-19 Patients: An Interview with Dr. Carla Watson

During these challenging times, we continue to be inspired by the dedication and innovativeness of our physiatrists. You are sharing your stories with us, of working in your communities, helping treat COVID-19 patients, innovative ideas you have started, and more. We’re speaking with a variety of AAPP&M members who are making a difference in our specialty so that we can share their stories with you. Look for additional stories from your peers in future issues of The Physiatrist and our other communications.

In this issue, we talked to Dr. Carla Watson of the OSF Little Company of Mary Medical Center in Evergreen Park, IL. Dr. Watson made a big transition when COVID-19 hit and directly treated patients that tested positive. The following article is based on her experience as of late June 2020.

Carla Watson, MD, FAAPMR
Physician Advisor
OSF Little Company of Mary Medical Center

As a board-certified physiatrist within the OSF Little Company of Mary Medical Center in Evergreen Park, IL, I, too, share a passion in our practice to do things differently than the way they have been done. This has not been easy but necessary, especially when faced with the current crisis. What I have learned is that the pandemic has shown us that we are capable of doing a lot more than we think we can.

As COVID-19 swept through the state of Illinois, our number of cases accelerated daily. The Chicago zip code we served was labeled a “hotspot.” Our daily grade changed from seeing patients to securing the hospital as ICU and PUC wards overflowed with COVID-19 positive patients. Instead of performing EMGs, my focus shifted to evaluating patients with COVID-19 who potentially qualified as ICU monitoring to create available beds which was a priority. A lack of personal protective equipment (PPE) and the need to limit access to patients, meantime coming up with a plan to redistribute our limited resources. We even restructured how our practitioners entered the building in order to decrease contact and flow of people entering the hospital. Naturally, there was a pause in the need for inpatient rehabilitation consultations. Our referring Inpatient Rehabilitation Facilities (IRF) and Skilled Nursing Facilities (SNF) weren’t yet prepared to accept COVID-19 patients early on. There were no guidelines on how to proceed. As an advisor to case management, our big issue was where to send these patients that needed to transition out of acute care but could not go home. Collaborating with the SNFs, we were able to help develop rules, regulations, and guidelines with the state to say, “Okay, if you do this, you will be able to safely accept the patient.” While this has helped, it’s still an ongoing process to direct people to care and get them access to care. The care that we, as physiatrists, are seeing develop before our very eyes.

In IRFU, usually by the time they get to us, we have a fairly clear rehab diagnosis, whether it’s stroke, amputation, TBI, etc. We have enough experience and data on just how hard it is to push these patients for desired outcomes. With COVID-19, we’ve had to take a more cautious approach. Patients could take three steps forward only to take another five steps back.

At OSF Little Company of Mary Medical Center, the majority of COVID-19 patients were too sick for rehab. We saw two extremes: those who were on and off the ventilator fighting for their lives and those who were really sick but needed to move a little bit. For the latter, it was about finding a balance of how much we push them to move safely. The scary element of it all was that we didn’t know.

As physiatrists, we need to get a handle on long-term effects of this disease. At this point we have some recommendations for early recovery stages but have yet to discover what late recovery truly looks like.

So, what can we do moving forward? We need to advocate for people to be tested. As more testing becomes available, we need to inform not just our patients, but our loved ones. A way to limit spread is by being more knowledgeable about our own status.

Finally, you need to be protective of the people around you, whether you’ve had the disease or not. I think everyone needs to recognize that although being close contact with other people, especially our family members, is what we crave, we have to recognize that in loving them in this climate, we could literally be loving them to sickness.

Orthopedic Associates of Hartford (OAH) is seeking a fellowship-trained Interventional Physiatrist who is Board-Certified/Eligible in Pain Management. OAH consists of 32 fellowship-trained physicians encompassing all of the major sub-specialties of Orthopedics to include Hand, Sports, Spine, Joint Replacement Surgery as well as Interventional Pain. OAH has 8 offices throughout the greater Hartford area, and service-line agreements with the Bone and Joint Institute at Hartford Hospital as well as with the Joint Replacement Institute at Saint Francis Hospital. It has ownership in four Ambulatory Surgical Centers, to include one that is 100% physician-owned, as well as ancillary services such as MRI and Physical Therapy. See our websites at www.oahct.com to learn more about our high quality practice.

The candidate would be joining two other Interventional Physiatrists in a fast-paced, high-volume practice focused primarily on non-operative management of acute spine pain, with an opportunity for sports medicine and team coverage. This is a 100% outpatient-only position, with no call responsibilities and a strong support team. The work will involve performing image-guided spinal injections in one of the surgical centers, in-office injections, and EMGs. There is a three-year path to full equity status. Opportunities for research are available. Please send CV and cover letter to: Richard Collins, Human Resources manager. rcollins@oahctmd.com.
Thank You to the 2020 IRC Participants!

The Industry Relations Council (IRC) is comprised of pharmaceutical and medical device companies that support therapeutic areas in the PM&R space. AAPM&R values the relationship with our partners and understands the importance of working together to advance the shared goal of improving patient care. Because of industry support, AAPM&R is able to pursue and achieve so many of the initiatives that help us reach our vision.

Each year, the IRC participants meet with the Executive Committee members of the Board of Governors and staff for a full-day meeting to discuss the current PM&R landscape and how to communicate the value of physiatry through advocacy, education, patient support, and more as well as to provide partners with an update on what is happening within the Academy.

This year’s robust meeting took place virtually on Friday, June 26. The main areas of focus for the meeting were:

- COVID 19: Current State and Predicting Future Projections of Physiatric Practice
- Current State of AAPM&R Strategic Plan
- New Now: Ways to Reach and Engage PM&R Physicians

We also had breakouts with the individual companies to hear what their current priorities are in the PM&R space.

FIND MORE INFORMATION AT WWW.AAPMR.ORG/IRC