THE
PHYSIATRIST
Physicians Adding Quality to Life®
August 2020 | Vol. 36 | Issue 8
aaPM&R

#AAPMR20'S VIRTUAL GAME PLAN—CONNECTING THE PM&R COMMUNITY

Join us online for the 2020 virtual Annual Assembly, November 12-15, with additional events beginning November 8, as Team Physiatry advances the specialty together during a week of collaboration, education, and fun!

The AAPM&R Annual Assembly is THE largest annual gathering of physiatrists in the world! It's where your Academy gathers together, collaborates together, and advances together. And in these challenging times, it's more important than ever that we unite as a specialty. So, we're bringing the PM&R community together to share best practices, reflect on lessons learned, and continue supporting each other. We hope you'll join us!

Check out some of the highlights on our real-time roster:

- Top-notch PM&R educational content curated by expert faculty to enhance your skill set and grow your career.
- Three pre-Assembly courses in ultrasound, spasticity and pain management, led by specialty thought-leaders who will provide real-world, clinically-applicable didactic and interactive case discussions.
- Live real-time clinical and practice symposia, plus pre-recorded on-demand sessions (accessible before and after the event)—all in an exciting, interactive format.
- Non-stop virtual networking opportunities—make connections, new friends and a lasting impression at #AAPMR20.
- Community sessions created specifically by your community leaders to address your community's unique needs and challenges.
- High-profile thought-leaders who will share their insights during our virtual plenary sessions. And don't forget PhyzTalks, where your peers will present inspiring stories of their PM&R community coming together for the greater good.

Find more information on #AAPMR20 at **www.aapmr.org/2020**.

Check out the back cover for more information on #AAPMR20 registration and pricing.

VIRTUAL aaPM&R ANNUAL ASSEMBLY NOVEMBER 12-15, 2020

GET READY FOR SOME PHYSIATRY DAY FUN!

Team Physiatry is excited for the fourth annual Physiatry Day celebration. We are finalizing our game plan, and we'll share next steps and how you can participate soon. In the meantime, plan to join us virtually on Friday, November 13. Save the date and get ready to share your love of the specialty! Stay tuned for more information at **www.pmrismorethan.org**.

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IN THIS ISSUE...

The Grace and Resilience of My Colleagues and Residents


Michelle S. Gittler
MD, FAAPMR

Greetings from Chicago!

I'm writing this in late June, but you will be reading it in August. At this moment, there are 19 states where new Corona infections are still on an upward trend. I have no idea what the world will be like in August. I am hopeful that overall new Corona infections will be on a downward trend, and we will all have a moment to catch our collective breath before the fall and winter flu seasons emerge!

I thought I would share with you some of my thoughts, as we celebrated our resident graduation. As you know, virtual graduations were de rigueur this year. Luckily, we had all had a crash course in Zoom or other technology for our meetings and lecture series which had prepared us for these remote/virtual celebrations. Of course, the best part of this for me was seeing people's families. What I loved was seeing parents, grandparents, in-laws and friends excitedly waving to and engaging in conversations with their graduate, without recognizing that there were 50 other people on the screen! It was fun to see the babies and the children, and to get a peek into everybody's home.

I recognized that no one could imagine the end of the residency in the way it occurred. How could any of us have envisioned a global pandemic, a modern-day plague, if you will? Residents had electives planned. Maybe they had already completed all of their calls, and were looking forward to pleasant spring and early summer evenings dining alfresco before they left the city their program was in. Maybe they had saved the best of their rotations for last, and this, sadly was the real-life lesson that you should always eat dessert first if you can! And if not dessert, then take that best bite of the sandwich right in the middle, eat the perfectly cooked French fry, or the best bite of pancake, the one with the crispy edge that is buttery and has the right amount of maple syrup on it. Because sometimes when you save something you are looking forward to for too long, you don't get to it. And that is always a shame.

We will all be telling stories of the pandemic for years to come, explaining to our children and our grandchildren what it was like when no one could go out to eat, the time of no movies in the theater, canceled weddings, and Zoom family holidays. We will be telling our residents and medical students about living through the pandemic. About how we learn to do telehealth. About coming to work with no traffic and making it in record time! About being scared. About bedazzling our masks. About how some of our units were closed altogether, and some of us worked in areas that maybe were not our sweet spot. And about how our patients had no visitors and what a lonely time it was for them.

> And here is the story I will be telling. I will be telling the story of the grace and resilience of my colleagues and of the residents. As our world turned upside down, we all pitched in as we could. We learned how to accommodate our colleagues needs, such as children at home with no daycare, pets that needed walking, family members who were sick. By learning to do this, to help each other, and to see the opportunity in the chaos, we were able to renew our humanism.

I tell the story that in opening our COVID-19 rehabilitation unit, I felt that my team was able to experience what interdisciplinary rehabilitation used to be. Before electronic medical records had us spending our time facing a screen. Most of the team members were volunteers, and together, we learned about the secondary effects and impairments attendant to the COVID-19 viremia. We took our time with team conferences, because GG codes really couldn't capture the complexities impacting our patients, or the improvements that our patients were making. We spent more informal time talking amongst ourselves: nurses, therapists, physicians and case managers in order to make sure that we all understood the ever changing plan. Together, we danced in the hallways as people went home. Together, we mourned with our patients who had sustained losses while they were hospitalized. Together, we demonstrated that interdisciplinary inpatient rehabilitation was the best solution for these patients.

I would love to hear your stories of your time during this plague. I hope you had some time for dancing in the hallways. Take care of yourselves, your families, your colleagues and your friends. ❖

With warmest regards,
Michelle

2020—The Year of Challenges and Changes


Ai Mukai
MD, FAAPMR

As we learn to adapt to the new world of COVID-19 and attention is directed to the medical field, we feel a sense of accountability to live up to the expectations of society to be healers and leaders in this tumultuous time. Our members have accomplished a lot in a short period of time. We have identified resources and shared strategies to safely but effectively care for our patients. We have learned unfamiliar technology to do virtual visits and utilized our network to bounce ideas off each other. We have advocated for our patients and our field. We have salvaged our business and coped with financial catastrophes. Some of us have transitioned to new jobs and have found niches where none existed before. The Academy has developed resources in record speed. You can check them out here: **www.aapmr.org/covid19**.

Social distancing and quarantine have also led to more self-reflection. I have spent more time contemplating my life, what I value and want to accomplish in my limited lifetime. I have also spent time reminiscing about all the things I took for granted. I have re-connected with people I have not connected with in years. (We had a virtual high school reunion on Zoom). Family has become more of a focal point and priority. As I navigate making choices for me and my family, it has been difficult to weigh the risks of our choices and understand the consequences, both intended and unintended, of those decisions. I have seen resilient people with great coping strategies whom I hope to emulate. I have also seen people and patients decompensate and become very depressed, angry, or anxious in this time of great stress. I have had very honest conversations with my patients about their stress and anxiety and have talked to them about getting mental health help. I have also re-discovered my love of music and cooking, and have spent hours perfecting my sourdough bread recipe and watching online courses on cooking techniques.

> More recently, I have spent a lot of time thinking about diversity, racism, sexism, bias, privilege, and opportunities. I am an immigrant, but I did not flee a negative situation in my home country. I have love for both my motherland and my new home. I appreciate the opportunities I have been given in this country, but I also have experienced some hardship to get to where I am today.

Like many physicians of color, I have been called racial slurs, been spat at, and kicked out of patient rooms. Like many female physicians, I have been asked, "Where is the doctor? When am I going to be able to talk to him?" or simply handed their meal tray to take away. I will eventually have to have a talk with my daughters about how they may not be able to get away with the same things as their white friends from school. At this time, my daughters think of racism as a thing of the past, in the days of civil rights movement and Martin Luther King, Jr. I still remember when my then kindergartener came home and asked me, "Mommy, if I were alive during that time, would I have to sit in the back of the bus?" Having to answer in the affirmative and to see the look of pain and anger on her young face while knowing the state of affairs that she will eventually encounter broke my heart. As I look to the future, I hope that this resurgence of awareness and drive to improve our current situation pays off.

> I hope that we can all unite in celebrating our differences while working to improve disparities. I am glad to see that the Academy has made a commitment to tackle this thorny topic and has established the Diversity and Inclusion Committee. While there are no perfect solutions and no single correct way to improve our current situation, I do think we need to have those difficult conversations.

I am proud of who I am and hope everyone feels a sense of pride for their unique attributes. As physiatrists, we have all had to work extra hard to prove our worth and value to others. We have a unique advantage in knowing how to adapt to changes, respond to challenges, and lead and show others how to persevere and thrive. ❖

ACADEMY IN ACTION

#PMRAdvocates: Academy Members Advocating for the Specialty

- Delegates to the PM&R Section Council of the AMA House of Delegates (HOD) held a virtual meeting on June 1 in preparation for the Special Meeting of the HOD held June 7. Due to the COVID-19 pandemic, the 2020 AMA Annual HOD Meeting was suspended and replaced with a condensed virtual meeting. Your AAPM&R delegation is represented by Susan Hubbell, MD, Chair, AAPM&R Delegate; Stuart Glassman, MD, AAPM&R Delegate; Carlo Milani, MD, AAPM&R Delegate to the Young Physician Section, AAPM&R Alternate Delegate; and Julie E. Witkowski, MD, AAPM&R Delegate to the Resident and Fellows Section, AAPM&R Alternate Delegate.

Telehealth and the Americans with Disabilities Act


Thiru M. Annaswamy
MD, MA

Guest Editor: Thiru M. Annaswamy, MD, MA; Secretary, Foundation for Physical Medicine and Rehabilitation

With the rapid adoption of telehealth by the medical community during COVID-19, many have seamlessly shifted to equivalent virtual health care and some patients have even enjoyed faster and easier access to their health care providers. This rapid adoption of telehealth affords several benefits to health care providers and patients alike: we are reducing exposure to the virus during the pandemic; our commute costs and burdens are lower; and the convenience of doing a telehealth visit from the comfort of your own home (for both providers and patients) cannot be overstated. However, for persons with disabilities—the patient population that we as physiatrists commonly serve—this acute change in the means of accessing health care has resulted in new barriers and challenges that they hadn't previously faced when interacting with the medical universe.

The Americans with Disabilities Act (ADA) was passed before the Internet and the Information Age. It created many protections as well as mandated removal of barriers for persons with disabilities accessing physical facilities and places of public accommodation. However, the ADA and similar laws urgently need to be modified to extend such protections and accommodations for persons with disabilities to interact with the increasingly digital world around them—including telehealth. Making telehealth platforms more accessible for persons with a wide range of disabilities such as hearing, visual, cognitive and physical disabilities must be a priority for the technology developers. However, an equal if not higher priority is the need for legislative overhaul of laws such as the ADA to expand coverage to this new digital world.

Technology companies that develop and maintain telehealth products that we use in our daily practice must be required to make their products "communicate effectively with their consumers and companions," just as Titles II and III of the ADA require of medical providers. Digital places such as virtual clinic rooms where telehealth interactions take place must be considered places of public accommodation to come under the purview of the ADA. For medical providers with disabilities, the definition of "places of work" needs to be redefined to include telehealth locations so that their employer may make appropriate accommodations, and laws pertaining to workplace accommodations need to be revised accordingly. Telehealth can be a great equalizer for persons with disabilities, but our health care policies and laws need to change along with the technology so that we can better keep pace with it.

Your Foundation for PM&R is currently working to raise funds and support research in these areas that will forever change the way we practice medicine and better serve our patients. Recent regulatory waivers have opened up a world of possibilities in telemedicine, exposing several areas of research that can be further explored. We will keep you posted on our progress via our Facebook and Twitter pages, our website (**www.foundationforpmr.org**), and email.

Please stay safe and continue to serve our patients as you always have. I thank you sincerely for your donations to the Foundation for PM&R! (**www.foundationforpmr.org/donate-now**) ❖

ACADEMY IN ACTION

Raising Physiatry's Voice: Your Academy Responds to Support its Members

- On May 20, your Academy supported a letter to maintain the physician workforce during the public health emergency by recapturing unused immigrant visas.
- On May 21, your Academy supported a Friends of VA letter that encouraged additional funding to the VA research program to support new VA research projects designed to address the effects of COVID-19 on veterans.
- On June 1, your Academy submitted comments responding to the Centers for Medicare and Medicaid Services COVID-19 Interim Final Rule (part 1). The comments addressed waivers in the IRF setting such as removal of the post-admission physician evaluation during the public health emergency, MIPS updates, and eight recommendations that were not included in the text of the interim final rule but that the Academy thought would be helpful.
- On June 3, your Academy (via the Consortium for Citizens with Disabilities) submitted a letter to Congress on coordinating Medicaid across state lines for children and adults with disabilities to receive adequate care.
- On June 9, your Academy supported an American Medical Association (AMA) letter asking Congress to include HR 7059 in any upcoming COVID-19 legislative package. This bill addresses limited liability protections during the public health emergency.
- On June 26, your Academy sent a letter to U.S. Department of Health and Human Services (HHS) Secretary Alex Azar in response to the Oklahoma's SoonerCare 2.0 Medicaid Section 1115 Demonstration Waiver. Oklahoma's proposed project includes work requirements, premiums, a per capita cap, and other harmful provisions that would reduce coverage and access to care, particularly for people with disabilities.
- On July 1, your Academy supported a letter to the Department of Health and Human Services (HHS) urging the agency to use its authority under the public health emergency to waive budget neutrality in its implementation of the new Evaluation and Management codes and values in 2021. If HHS moves forward with this recommendation, it would avoid significant cuts to payment across the Physician Fee Schedule.
- On July 8, your Academy submitted comments to the Centers for Medicare and Medicaid Services (CMS) COVID-19 Interim Final Rule (part 2). The comments thanked CMS for extending additional waivers including increasing payment for audio-only telehealth services to mirror the rates for similar services provided using audio/visual telehealth.

Imagining a BOLD Future Early in the Rehabilitation Care Continuum


Miguel Escalon
MD, FAAPMR

Together, the specialty of PM&R BOLDLY discussed its future. AAPM&R enlisted the assistance of physiatrists across the Rehabilitation Care Continuum (RCC) to envision the future of physiatry aligned with the vision for physiatry.

That vision states that in the future, we see the physiatrist as the recognized leader across the acute and post-acute care continuum with expertise in managing utilization of resources to achieve maximal patient outcome.

- This includes traditional roles as the leader in Inpatient Rehabilitation Facilities, as well as in other acute and post-acute settings.
- Early physiatric intervention offers every patient a baseline assessment of critical function and enhances appropriate post-acute care management.
- Physiatrists provide cohesion of clinical care through the development of care pathways, co-managing models for high-acuity patients, and managing post-acute provider networks to provide timely, efficient, and valuable care and leadership.
- Health care systems and payers value physiatry for timely and efficient transitions, decreased lengths of stay and hospital readmissions, improved efficiencies, reduced potential medical errors and secondary complications, minimization of unnecessary tests, reduced patient anxiety, and improved compliance.

We spoke with Miguel Escalon, MD, FAAPMR, at the 2019 Annual Assembly in San Antonio and recently followed up with him to get his perspective on physiatry's work across the Rehabilitation Care Continuum as well as his frontline work during the COVID-19 pandemic. As a physiatrist working in the ICU at the Icahn School of Medicine at Mount Sinai, he was practicing in New York during the height of COVID-19. Since entering practice in 2014 following a spinal cord injury fellowship, he finds himself doing a bit of everything and spending a lot of time early in the care continuum with patients in the various Intensive Care Units at Mount Sinai.

"Historically, there are a few intensive care units where you might find physiatrists, including trauma units, burn units, and neurological units. Well, I find myself in all of them including units like transplant, surgical, and cardiac. Eight or nine intensive care units exist at Mount Sinai and [the physiatric presence in each of them] has a trickle-down effect to our inpatient rehab units. We get patients that are not traditional 'bread-and-butter' rehab patients," said Dr. Escalon.

"My work in the ICU is growing. When we started seeing patients in nontraditional ICUs, it was under the auspices of early mobilization. There was data that suggested early mobilization would be important to decrease length of stay, which was important from the system perspective. The more that I work in the ICU, the more it feels like what I was trained to do on any inpatient rehab unit. We have team rounds there and they run similarly. They run much faster and more often because there's a lot of turnover, but the whole idea is the same. We have our ICUs talking about disposition, making mobility level goals, and we have delirium teams. Plus, we have all kinds of other things that have grown from what started with the basic idea of early mobilization."

In San Antonio last fall, Dr. Escalon noted "There's nothing to keep us from helping anyone. The nice thing is we can apply our expertise in quality-of-life and function to any population." With this philosophy, we wanted to check back in with Dr. Escalon after the peak of the COVID-19 pandemic hit his area in New York.

Dr. Escalon noted of COVID-19 cases, "Patients are sick in a way that we're still learning how to deal with. As a specialty, we have an opportunity to get creative early on. We know there are certain issues such as sedation and prone position; how do we get creative? How do we stay at the forefront of this?"

The relationships he has established throughout Mount Sinai early in care did allow for rehabilitation to be thought of early and often: "Intensivists were calling and asking for therapy." However, Dr. Escalon and his colleagues are looking at data to evaluate mobilization of COVID-19 patients and what can be learned.

Overall, Dr. Escalon is proud of the relationships that have been built across the system and the value his non-PM&R colleagues see in rehabilitation and the role of the physiatrist. "I had [an ICU colleague] tell me recently that they felt more fulfilled now thinking about all these things such as mobilization, disposition, and what happens next? What are we really doing for our patients here?"

When asked about the larger vision for PM&R and across the entire rehabilitation care continuum, Dr. Escalon noted that we "need to grow roots in every direction, toward both post-acute and acute care, either by putting ourselves in ICUs or bringing sicker patients onto Inpatient Rehabilitation." There are opportunities at every point across the rehabilitation care continuum for physiatry to show its value and that remains as we continue to battle this pandemic, and look toward our future role in health care.

To learn more about Advancing PM&R BOLD, additional practice areas, and how you can get involved, visit **bold.aapmr.org**. ❖

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IMPORTANT SAFETY INFORMATION
INDICATIONS AND USAGE

XEOMIN® (incobotulinumtoxinA) for injection, for intramuscular or intraglandular use, is a prescription medicine that is used to treat adults with:

- chronic sialorrhea
- cervical dystonia
- upper limb spasticity
- blepharospasm

WARNING: DISTANT SPREAD OF TOXIN EFFECT
See full prescribing information for complete BOXED WARNING

The effects of XEOMIN and all botulinum toxin products may spread from the area of injection to produce symptoms consistent with botulinum toxin effects. These symptoms have been reported hours to weeks after injection. Swallowing and breathing difficulties can be life threatening and there have been reports of death. The risk of symptoms is probably greatest in children treated for spasticity but symptoms can also occur in adults, particularly in those patients who have underlying conditions that would predispose them to these symptoms.

Please see Important Safety Information on the next page. Please visit https://www.xeomin.com/healthcare-professionals for additional Important Safety Information and Full Prescribing Information, including BOXED WARNING.

10 YEARS

IMPORTANT SAFETY INFORMATION (continued)
CONTRAINDICATIONS

- Known hypersensitivity to any botulinum toxin product or to any of the components in the formulation.
- Infection at the proposed injection site(s) because it could lead to severe local or disseminated infection.

WARNINGS AND PRECAUTIONS

- The potency units of XEOMIN are specific to the preparation and assay method used and are not interchangeable with other preparations of botulinum toxin products. Therefore, Units of biological activity of XEOMIN cannot be compared to or converted into Units of any other botulinum toxin products.
- Serious hypersensitivity reactions have been reported with botulinum toxin products (anaphylaxis, serum sickness, urticaria, soft tissue edema, and dyspnea). If serious and/or immediate hypersensitivity reactions occur, discontinue further injection of XEOMIN and institute appropriate medical therapy immediately. The use of XEOMIN in patients with a known hypersensitivity to any botulinum neurotoxin or to any of the excipients (human albumin, sucrose), could lead to a life-threatening allergic reaction.
- Treatment with XEOMIN and other botulinum toxin products can result in swallowing or breathing difficulties. Patients with pre-existing swallowing or breathing difficulties may be more susceptible to these complications. When distant effects occur, additional respiratory muscles may be involved. Patients may require immediate medical attention should they develop problems with swallowing, speech, or respiratory disorders. Dysphagia may persist for several months, which may require use of a feeding tube. Aspiration may result from severe dysphagia *[See BOXED WARNING]*.
- Individuals with peripheral motor neuropathic diseases, amyotrophic lateral sclerosis, or neuromuscular junctional disorders (e.g., myasthenia gravis or Lambert-Eaton syndrome) may be at increased risk for severe dysphagia and respiratory compromise from typical doses of XEOMIN.
- **Cervical Dystonia:** Treatment with botulinum toxins may weaken neck muscles that serve as accessory muscles of ventilation. This may result in critical loss of breathing capacity in patients with respiratory disorders who may have become dependent upon these accessory muscles. There have been post-marketing reports of serious breathing difficulties, including respiratory failure, in patients with cervical dystonia treated with botulinum toxin products. Patients with smaller neck muscle mass and patients who require bilateral injections into the sternocleidomastoid muscles are at greater risk of dysphagia. Limiting the dose injected into the sternocleidomastoid muscle may decrease the occurrence of dysphagia.
- **Blepharospasm:** Injection of XEOMIN into the orbicularis oculi muscle may lead to reduced blinking and corneal exposure with possible ulceration or perforation. To decrease the risk for ectropion, XEOMIN should not be injected into the medial lower eyelid area.
- XEOMIN contains human serum albumin. Based on effective donor screening and product manufacturing processes, it carries an extremely remote risk for transmission of viral diseases and variant Creutzfeldt-Jakob disease (vCJD). There is a theoretical risk for transmission of Creutzfeldt-Jakob disease (CJD), but if that risk actually exists, the risk of transmission would also be considered extremely remote. No cases of transmission of viral diseases, CJD, or vCJD have ever been reported for albumin.

ADVERSE REACTIONS

The most commonly observed adverse reactions at rates specified below and greater than placebo are:

- **Chronic Sialorrhea:** (≥4% of patients) tooth extraction, dry mouth, diarrhea, and hypertension.
- **Upper Limb Spasticity:** (≥2% of patients) seizure, nasopharyngitis, dry mouth, upper respiratory tract infection.
- **Cervical Dystonia:** (≥5% of patients) dysphagia, neck pain, muscle weakness, injection site pain, and musculoskeletal pain.
- **Blepharospasm:** (≥10% of patients) eyelid ptosis, dry eye, visual impairment, and dry mouth.

DRUG INTERACTIONS

Co-administration of XEOMIN and aminoglycoside or other agents interfering with neuromuscular transmission, (e.g., muscle relaxants), should only be performed with caution as these agents may potentiate the effect of the toxin.

Use of anticholinergic drugs after administration of XEOMIN may potentiate systemic anticholinergic effects. The effect of administering different botulinum toxin products at the same time or within several months of each other is unknown. Excessive neuromuscular weakness may be exacerbated by administration of another botulinum toxin prior to the resolution of the effects of a previously administered botulinum toxin.

USE IN PREGNANCY

There are no adequate data on the developmental risk associated with the use of XEOMIN in pregnant women. XEOMIN should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

PEDIATRIC USE

Safety and effectiveness of XEOMIN in patients less than 18 years of age have not been established.

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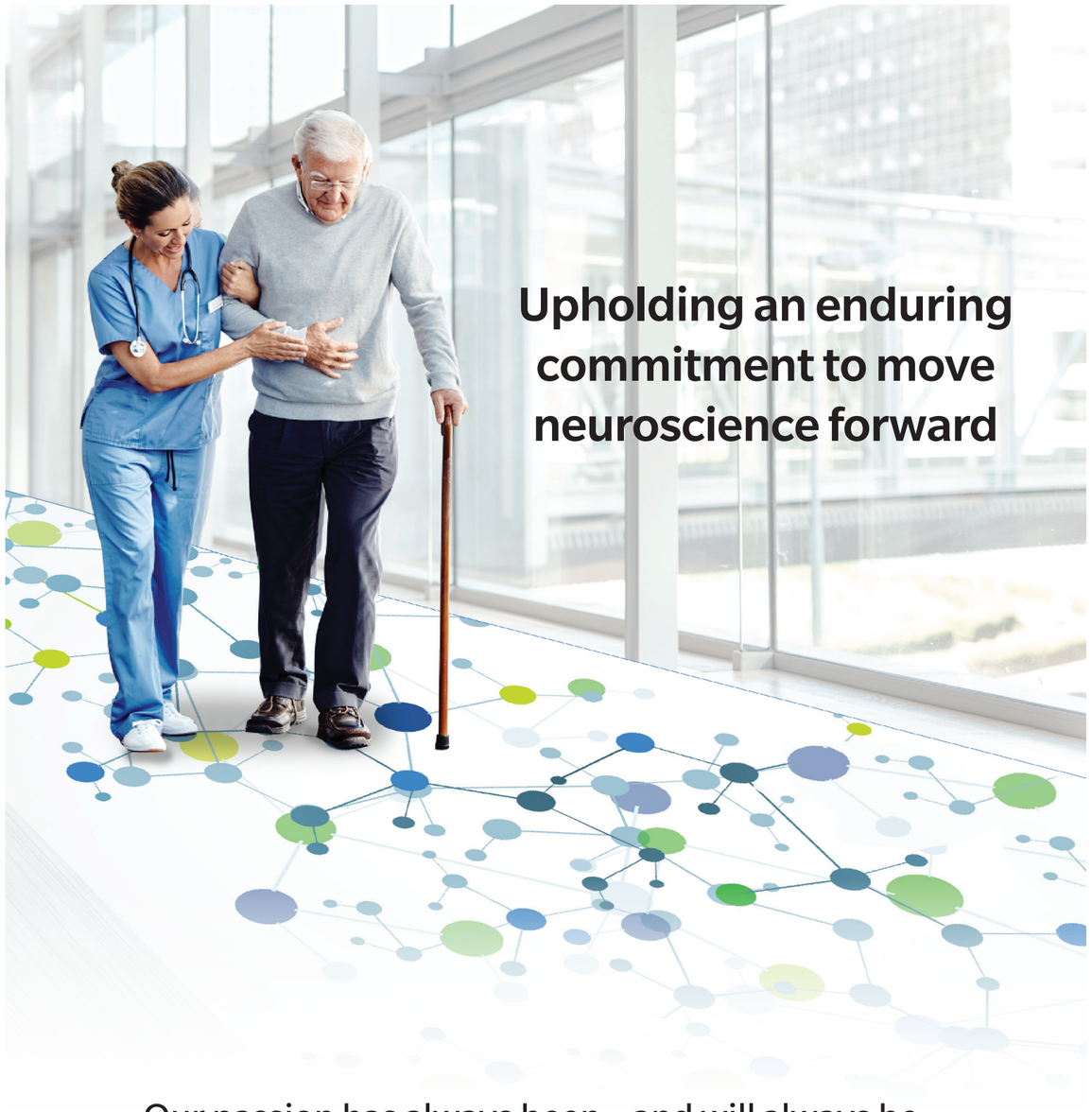

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Further, Together

Climate or not to Climate, That is the Question

Justin Bishop
MD, MBA, MS

In a prior life, I swam with the fishes and I am not talking in the cliché way. My passion for the environment led me to a life in marine biology but with time, no matter how much I dedicated my life to the cause or finished numerous studies finding significant correlations of human behavior affecting climate, a majority of people either listened and did not care or just straight-up didn't listen—preventing a conversation all together. Despite strong research showing an increase in climate change from unnatural causes, there is still more information that is unknown and that is important for future conversations, especially when it comes to our specialty and patients. Currently within PM&R literature, climate-related publications are in the single digits, almost exclusively focused on disease-specific issues with climate not a focus.

Because the research trends show an increased effect on our communities/patients (not soon but now) along with the deficiency of knowledge within PM&R specifically, our AAPM&R Board of Directors approved the recommendation to have AAPM&R representation on the Medical Society Consortium on Climate and Health (MSCCH). This national organization represents the interests of 27 national medical academies, colleges and can now represent the Academy with its advocacy and scientific resources as well as its many collaborations. Due to AAPM&R's foresight, we now have an additional arm to help our specialty and I, along with Sarah Hwang, MD, FAAPMR from the Shirley Ryan AbilityLab, are proud to represent our PM&R community on this group.

The MSCCH is only four years old, and this young but quickly growing organization, is working very closely with all the major colleges/academies, crafting an extensive number of statements and lobbying on the Hill. Dr. Robert McLean, the immediate past president of the American College of Physicians, has just been named chair and will work closely with their new vice chair (yours truly) to help move things in a direction that will help all of medicine. This shouldn't be too strenuous because the MSCCH, despite its age and relative size to other organizations, has an unexpected amount of resources, is well-connected, and has strong relationships that make the already proactive, focused approach in DC very effective.

Since AAPM&R joined the MSCCH in late February 2020, activity was ramping up until COVID-19 made its way to the stage. We had some elections, signed on to various statements, and had begun working on organizational restructuring that typically occurs within a growing organization. There was going to be an annual meeting on May 17-18 but that was replaced with a much-abridged virtual conference to try and learn more about our members as well as finalize our priorities for moving forward. Unfortunately, the abridged virtual format could not include the lobbying opportunity. Though the problems from COVID-19 seem endless, there does seem to be a slight increase in attention to the medical/scientific community—a moment we should capitalize on as disseminating facts to people, particularly legislators, is paramount in moving the advocacy needle. If society is more open to listening to the scientific facts now as a result of this tragedy, we need to take advantage of this time to educate on how climate change affects everyone, and specifically its disparate effect on our physiatric patients.

There has been some discussion on PhyzForum about the pros and cons of this new venture, which was very much appreciated. This internal, community-driven PM&R engagement is necessary to drive and direct our external lobbying efforts with the MSCCH. I would like to reiterate that this is a win-win for our medical community and organization. We can leverage our voice within another group to push our agenda and demonstrate the expansive value of PM&R. We can use MSCCH's advocacy arm to help the climate and ourselves. We can have more resources to use and much learn along the way. And as far as costs are concerned, so far there haven't been any, except my volunteer time, which is no cost at all because I love this! Like I said, a win-win. Moving forward, I hope that we incorporate more climate change into the PM&R dialogue (i.e., disaster relief, SCI/mobility related issues, MS, pulmonary rehab, zoonotic caused neuropathy, etc.) and utilize this new partnership as best we can.

Dr. Hwang and I look forward to helping this initiative grow. Be sure to check out the MSCCH website (**medsocietiesforclimatehealth.org**) for more information and share your thoughts on PhyzForum, or email **healthpolicy@aapmr.org** so we can keep this conversation going. ❖

ACADEMY IN ACTION

Raising Physiatry's Voice: Your Academy Responds to Support its Members

- Your Academy supported a letter from the Federation of American Hospitals asking Congress to clarify the tax implications of the Public Health and Social Services Emergency Fund (PHSSEF) and other programs as part of the nation's response to the novel coronavirus (COVID-19) pandemic, similar to how they made tax implication clarifications for the PPP.
- Your Academy submitted asks related to COVID-19 to Congress to guide them as they draft the upcoming COVID-19 legislative package. The letter includes asks on ensuring access to personal protective equipment and COVID-19 testing, providing liability protections during the public health emergency, maintaining the physiatry workforce by supporting bills (S. 3599 and S. 948) that address ways to recapture immigrant visas for American-trained immigrant physicians to continue working in America, expanding telemedicine reimbursement, waiving student loans for physicians, providing access to rehabilitation care for the uninsured, ensuring social determinants of health are addressed as we know COVID-19 is having a disparate impact on minority communities, and maintaining waivers in Inpatient Rehabilitation Facilities (IRFs) for COVID-19 patients such as the waiver of the three-hour rule and 60% rule.

THE PHYSIATRIST

aaPM&R
American Academy of
Physical Medicine and Rehabilitation

9700 W. Bryn Mawr Ave., Suite 200
Rosemont, Illinois 60018
phone 877.AAPMR 99
fax 847.754.4368
info@aapmr.org www.aapmr.org

NON-PROFIT
ORGANIZATION
U.S. POSTAGE
PAID
PERMIT NO. 6585
CHICAGO, IL 60601

Published 10 times a year as a service to the members of the American Academy of Physical Medicine and Rehabilitation.

PRESIDENT, AAPM&R
Michelle S. Gittler, MD, FAAPMR

EXECUTIVE DIRECTOR & CHIEF EXECUTIVE OFFICER
Thomas E. Stautzenbach, MA, MBA, CAE

EDITORS-IN-CHIEF, *THE PHYSIATRIST*
Ai Mukai, MD, FAAPMR and Elliot Roth, MD, FAAPMR

CONTACT
The Physiatrist: submissions@aapmr.org

Subscription rate for members is $20, which is included in the dues.

Send address changes to:
The Physiatrist, 9700 W. Bryn Mawr Ave., Suite 200, Rosemont, IL 60018-5701 or info@aapmr.org, or update your member profile online at www.aapmr.org.

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