American Podiatric Medical Association

Young Members' e-Exchange

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Calling All Leaders!
Getting Involved after Podiatric Medical School

Beth Noe, DPM

While obtaining your podiatric education, many of you were involved in student government, clubs, or sports teams. Then you started residency, and your ability to get involved was limited by two things: time and lack of opportunities. Then you may have graduated residency and started as an associate or started your own practice, and again, getting involved was limited by the same two things. This article is going to address one of those two limiting factors: lack of opportunities.

You must start by maintaining your membership in APMA and your state component society. To do so, visit the APMA Web site (www.apma.org) to find out about the application process for your state. Remember that as a young member, your APMA dues are reduced!

Once you have obtained membership with your state association, attend a meeting. Talk to the current members, and express your desire to get involved. At each meeting, committees often are formed to look into different topics concerning podiatrists in that state. Find one that interests you, and volunteer. If time is an issue, tell someone, and perhaps that person can recommend a committee with less time commitment. If your state has a Young Member position or committee, this would be the perfect opening for you. Take advantage of the opportunities—there are many!

If you are a member of an APMA affiliated organization (ACFAOM, AAPPM, AAWP, etc.) this is another way to get involved. These organizations are often looking for new practitioners to serve on committees and infuse new ideas into the group. If you belong to an organization but are unsure of the benefits that are pertinent to you as a young member, volunteer to serve on a committee to bring these concerns to light. Change can happen only if a need is recognized. See the full list of APMA recognized organizations on www.apma.org.

You may not be able to do much about the time factor, but remember that you were once able to make it happen while you were studying for anatomy, biochemistry, and physiology all at the same time. It is possible that you can manage your time and still be involved. The profession needs leaders and new, fresh ideas. Get involved, and don't

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In This Issue

Have you moved lately?
If so, have you notified APMA?
If not, please send your new address to
Membership_ask_apma@apma.org

Past issues of the Young Members' Exchange can be found on the web at www.APMA.org/exchange

This newsletter, developed with support from Podiatry Insurance Company of America (PICA), is designed to inform the young member on topics relating to students, residents and young practitioners. YMC and APMA extends its appreciation to PICA for its support and innovative ways of bringing information to the young member.

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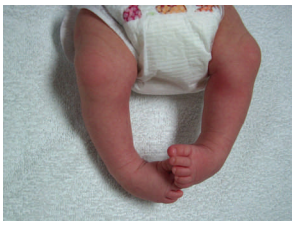
sit back and wait for others to make the changes. Participate in your profession beyond the doors of your office or residency!

The Gold Standard of Clubfoot Treatment: A Personal Account

Eric Riley, DPM

As I stand over my wife (who is undergoing a planned C-Section for the birth of our second child) in the delivery room, I am nervously awaiting the safe and healthy arrival of our son. The skilled ob-gyn leading this operation holds up the tiny prize, who is hollering from having to leave the sanctity of the womb. Up goes my son, and I all I can think is "He has *talipes equinovarus*!" Oh, *MY GOSH*. I rush from my wife's side over to the warmer where my son is being evaluated and proceed to have a discussion with the nurse practitioner, who assures me that my son's feet are normal. Little does she know that I am a podiatrist trained in the Ponseti method and a survivor of clubfoot myself.

Idiopathic clubfoot is the most common congenital deformity of the foot.[1] Its characteristic presentation of equinus, varus, adductus, and cavus deformities makes it easily recognizable. Early diagnosis is paramount, and beginning in the 16th week in utero, the condition can be seen on ultrasound. Because the deformity is so apparent at birth, it can be devastating for parents to see their newborn with a foot that is essentially turned upside down. (Trust me, I know firsthand!)



Demographically, clubfoot occurs in approximately 1 in every 1,000 live Caucasian births. It occurs less in the Japanese population by as much as half, and in South African blacks it occurs as much as three times as frequently; in Polynesians, it occurs six times as frequently. It has a male-to-female sex predilection of 3:1 and 40 percent of cases are bilateral.[2–4]

The exact pathogenesis of clubfoot is not well understood, however, the literature has pointed in the direction of a genetic origin. Numerous studies have documented this source, as well as various associations of clubfoot with other neuromuscular diseases.

Ignacio Ponseti, MD, developed a nonoperative treatment for clubfoot that yields nearly 90% effectiveness. His method has been well established in the literature and has 30-year, and now 50-year, follow-up data showing superior results compared with those of surgical intervention.[5–6] Developed in 1948, and not without continued scrutiny, the method continues to reduce or eliminate all the components of congenital clubfoot, so that the patient has a functional, pain-free, normal-looking, platigrade foot with good mobility and requires no modified shoes— this being the fundamental goal of treatment.

Briefly, the guidelines for treatment of clubfoot are as follows:

1. All the components of the clubfoot deformity have to be corrected simultaneously, with the exception of the equinus, which should be corrected last.
2. The cavus, which results from a pronation of the forefoot in relation to the rearfoot, is corrected as the foot is abducted by supinating the forefoot and thereby placing it in proper alignment with the rearfoot.
3. While the whole foot is held in supination and in flexion, it can be gently and gradually abducted under the talus, secured against rotation in the ankle mortise by applying counterpressure with the thumb against the lateral aspect of the head of the talus.
4. The heel varus and foot supination will self-correct when the entire foot is fully abducted in maximum external rotation under the talus. The foot should *never* be everted.
5. Now the equinus can be corrected by dorsiflexing the foot; the Achilles tendon may need to be percutaneously lengthened to facilitate this correction. A transition into a strict bracing is key to maintaining correction.

The pathology and functional anatomy of the clubfoot and the structural/morphological changes in its ligaments, tendons, and muscles must be well understood to arrive at an early and appropriate diagnosis and initiate the gold standard of care: nonoperative treatment. We owe it to our patients as foot and ankle physicians to provide evidence-based and continually reviewed treatment. The Ponseti method clearly offers superior treatment for the clubfoot patient.

Further information on Ponseti training is available at
http://www.ponseti.info/v1/
http://www.uihealthcare.com/topics/medicaldepartments/orthopaedics/clubfeet/

So, for those of you who are wondering, after the Ponseti method and bracing were applied, my son's feet are now within normal limits. Well, time for me to go be a dad instead of a podiatric physician for a while!

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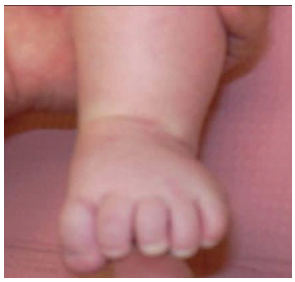

Practice Management:
Mistakes That Can Cost You Money
Part 3 and 4 of 10
Jonathan Moore DPM, MS

Is it possible to be losing 12 percent of revenue due just to being careless in how you manage your practice? According to some experts, this number actually may be conservative.

3. Scheduling inefficiently

No shows cost you. Bottom line: If you don't have a staff person calling patients the day before their appointments, you may want to start. It works. Train this person well, and he or she will make you sound good.

Another easy solution to the woes of scheduling is to look closely at those days or evenings that you have sparsely filled appointment slots. If this is a regular phenomenon, cut back to two nights a week or make some modification to justify keeping the practice open. Don't pay for salaries and utilities unless you are generating money.

Experts advise that if your practice doesn't lack for patients, open another appointment slot or two per day by rearranging your schedule. This almost always generates significant additional revenue per physician.

Although much is written about how to modify and adapt your schedule to maximize efficiency, the key point is to be aware that inefficient scheduling will cost you money.

Review trends in your practice, and don't be afraid to make changes and try them.

Most importantly, train your staff how to appoint specific types of patients. In other words, make sure your software has the ability to put a 5-minute wart patient in a smaller time slot than a new heel pain patient. Scheduling 20 minutes for a 5-minute patient will kill you over time.

4. Not registering associates promptly

If you are thinking about hiring that new associate, get the registration process with payers rolling as early as you can. Most experts say four-six months before the start date is about right. If you start too late, you will find yourself floating your new associate with money out of your pocket.

Make sure your office manager starts the enrollment process early and aggressively. Many insurance companies are not only slow—they are downright cantankerous. If something doesn't come when you expect it, get on the phone. Time in this case really does cost you money.

Once the application is submitted, the office manager should follow up every 30 days to make sure the plan will pay for patients the new doctor sees beginning on the first day.

Most applications will need your tax ID as well as the new associate's provider number.

If you are launching out on your own, don't forget you have to also have a street address for the practice, which means you need to have an office address before registering.

If you are a resident getting ready to start practice, much of this holds true as well. Start early getting your Medicare number, as you will need this to apply for most private insurance.

5. Failing to collect copays

Is your front desk staff trained to be conscientious about collecting copays at the time of the visit? If not, experts estimate you could be losing up to $20,000 a year or more.

If you think that sending a bill to a patient is just as good as collecting the money at the time of service, *think again.* If your practice misses the opportunity before the patient leaves your office, mailing out a bill may be a waste of time. Sending a bill out manually will cost you money, and in some cases, it may not even be worth the effort when you take into account staff and time.

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Put your payment policy in writing, and share it with new patients at their first visit. Since some patients will still show up at your office without cash or checkbook, be ready to accommodate credit cards.

Even if your staff stays on top of collecting copays for routine services, you may be missing the boat on copays for preoperative, postoperative, and physical therapy.

Make sure your front office staff are trained to know when copays are due. And most importantly, train your staff to smile. Never forget: The first face your patients see when they walk in your door is the same face they see when they are writing you a check. If you have craggy, rude, or unfriendly front office staff, patients will not leave with a good feeling after having paid. Some may not even want to pay.

Customer service is not only about being nice, it is about being professional. Make sure your staff is trained in how to ask for payment in a way that is appropriate, effective and friendly.

The 2009 Midwest Podiatry Conference invites you to join us April 2-5, 2009 at the Hyatt Regency Chicago. The 2009 program will offer a variety of programming and workshops for all levels of skill for podiatrists, podiatric medical assistants, residents and other related healthcare specialists. We also welcome back the ASPMA who will be hosting their 4th annual meeting in conjunction with the Midwest. The Midwest is also a great venue to check out the latest in podiatric equipment and supplies with over 275 exhibitors showcasing the newest products and services. For more information visit http://www.midwestpodconf.org

Registration begins December 1, 2008

HOTEL INFORMATION

HYATT REGENCY CHICAGO
151 E. WACKER DR.
CHICAGO, IL 60601
312/565-1234 or 1-888/421-1442

Room Rates
Single Room: $199
Double Room: $199

Room rates are guaranteed based on availability through March 10, 2009.

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