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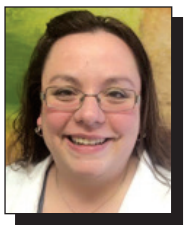
Jennifer Spector, DPM

The Current Health of Podiatric Medicine

How is the profession handling its greatest challenges?

BY MARC HASPEL, DPM

Save for the daily interactions that podiatric physicians have with their patients involving treatments and outcomes, podiatric medicine looks very little like it did a generation ago. Sweeping changes in patient insurance and reimbursement models, influenced most notably by the Affordable Care Act, have forced practitioners to confront new realities inconceivable in the past. In general, faced with eroding reimbursements and the overall decline in fee-for-service payment, many podiatric physicians have responded by seeking new practice arrangements, forming both small partnerships and regional super groups.

Additionally, so-called niche practices have emerged that have attempted to attract patients away from potentially over-crowded and weakly-serviced traditionally-based insurance practices. Of course, hovering over the profession are continuing concerns about a residency crisis that has impacted other specialties in allopathic medicine as well. This crisis seems to wax and wane a bit with the number of students matriculating into the colleges of podiatric medicine, although concerted efforts in recent years have begun to alleviate the situation. And of course, a conversation about the health of podiatric medicine always seems to include the question of degree change from DPM to MD. Though the question of degree change remains highly controversial, acknowledged parity with other allopathic physicians appears to be the remedy this profession needs at this time.

So, considering all of these formidable challenges, just how healthy is the patient (podiatry)? *PM* invited a panel of well-respected podiatric leaders to discuss these and other pertinent issues surrounding the profession. We found their responses insightful and enlightening, and we think you will as well. Joining this roundtable:

James Christina, DPM is currently Executive Director/CEO of the American Podiatric Medical Association and prior to that was Director of Scientific Affairs for 10 years for APMA. Dr. Christina is a diplomate of the American Board of Foot and Ankle Surgery, a member of the American Diabetes Association and the American Public Health Association, and has received both the Stephen W. Toth and John Carson distinguished service awards from the Podiatric Health Section of the APHA.

Jon Hultman, DPM is the executive director, California Podiatric Medical Association (CPMA). He is a former assistant clinical

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Strethoscope: © Sashkinw | Dreamstime.com

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professor at UCLA Medical School, chief executive officer of Integrated Physician Systems, and president of CPMA. He is the author of *Reengineering the Medical Practice* (1994), *The Medical Practitioner's Survival Handbook* (2012), and 450 published articles. Dr. Hultman is a recipient of *PM's* Lifetime Achievement Award.

Jeffrey Lehrman, DPM is in private practice in Philadelphia, PA. He holds fellowships with ASPS, ACFAS, and AAPPM, and serves on the board of directors of both the APWCA and ASPS. He is on the editorial advisory board of *WOUNDS* and is on the APMA Coding Committee. He has lectured nationally and internationally on practice management issues.

Jonathan Moore, DPM is board certified by the American Board of Podiatric Medicine, and is managing Partner, Cumberland Foot and Ankle Centers of Kentucky. He is fellowship director of the Central Kentucky Diabetes Management Fellowship and is a fellow and member of the board of trustees of the American Academy of Podiatric Practice Management. He serves as adjunct faculty member of Kent State University School of Podiatric Medicine.

Hal Ornstein, DPM is founder, chairman, and chief executive officer of the New Jersey Podiatric Physicians and Surgeons Group, LLC; president of Podiatric Super Group Management, LLC; president of the Institute for Podiatric Excellence and Development, and chairman of the Foundation of Podiatric Excellence and Growth. A noted author and presenter, in 2009, he was honored to receive induction to the *Podiatry Management* Hall of Fame.

Jennifer Spector, DPM practices with Cafengiu Podiatry and Sports Medicine in Marlton, NJ. She is the current secretary of the American Association for Women Podiatrists, and conference chair for its upcoming 2016 Scientific Conference.

PM: *How do you see Obamacare affecting the health of podiatry, both in terms of quality of care and the increasing numbers of patients with healthcare coverage?*

Christina: The Affordable Care Act is impacting the entire practice of medicine. Unfortunately, as we are now seeing, some ACA insurance products are losing money for insurers and they are increasing premiums and/or decreasing reimbursement to providers of care. Another problem is that the group of people who, in general, could not afford healthcare premiums is now getting coverage, but often with high deductibles. Potentially, podiatric physicians could end up not being able to collect the high deductibles, essentially having to provide care for no reimbursement. Finally, for those patients who get coverage under Medicaid as a result of the ACA, there is often an extremely low reimbursement for services provided by podiatric physicians, and often limitations on what those podiatric services cover. In general, I see nothing in the ACA to lead to any improvement in quality of care.

Unfortunately, as we are now seeing, some ACA insurance products are losing money for insurers and they are increasing premiums and/or decreasing reimbursement to providers of care.—Christina

Lehrman: No change in health insurance policy should impact the quality of care podiatric physicians provide. Podiatric physicians take an oath to provide the very best care possible, and are obliged to keep that promise. If physicians feel the healthcare environment is having a negative impact on the quality of care they are delivering, then they need to re-assess the manner in which they practice. This is not only an ethical issue, but also one that relates to reimbursement. Moreover, CMS has a published goal of tying 90% of reimbursement to quality by the end of 2018. Nothing should get in the way of podiatrists providing care that is of the highest quality.

Hultman: It is important to note that Obamacare does not replace private insurance, Medicare, or Medicaid, and it does not regulate health. It regulates health insurance. Certainly, some of the new patient protection measures, such as coverage for pre-existing conditions and elimination of life-time dollar limits, are good for patients and doctors alike. Similarly, expanding Medicaid and providing affordable health insurance are good because these measures open access to DPMs for a greater population of patients. What is not so good is achieving the stated goals of quality and reducing the growth in U.S. healthcare spending. All attempts at fixing healthcare have had the same over-arching objectives, which are to do more with less, and do it better.

The problems are that physician practices utilize different software programs and treatment protocols, and participating health plans have different fee schedules, rules, and network sizes. Conversely, quality and cost-savings are achieved through standardization, simplification, elimination of bureaucratic bottlenecks, reduction of variation in treatment outcomes, and network sizes, which are optimal for balancing patient volume with available providers. Most current health plans are doing the exact opposite.

Ornstein: The advent of Obamacare was originally seen as an opportunity to increase a patient base for physicians. With increased numbers of Americans with insurance and better access to healthcare, there was hope for greater access to podiatrists. The opposite effect, however, was rather quick to man-

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ifest itself. The greatest challenges with Obamacare have been the high deductibles, co-payments, and co-insurances for the newly insured. Those who were previously insured with reasonable deductibles are also now entered and obligated into Obamacare tiered plans, which impose deductibles that are now too high.

This creates a rather large barrier to obtaining medical care, burdening those already financially challenged with elevated co-pays that they cannot literally afford. For those previously insured, Obamacare just created a larger barrier to affordable medical care access due to the high co-pays and other costs.

Moore: As several of my colleagues have mentioned, Obamacare promised coverage for those who couldn't afford coverage. In that respect, at least in my community, I see a lot more patients who prior to the enactment had no coverage. Despite the fact that coverage most certainly resulted in more patients in my practice, what was given was a level of coverage that in many ways was significantly superior to any other plan that my Walmart or factory patients previously had. I think is has been good for my practice, but at a considerable cost.

Many of the Obamacare plans I have encountered have significant coverage limitations that then affect the care plan I can realistically implement.—Spector

Spector: I think it's not just a matter of quality of care and presence/absence of coverage, there's also the quality of the coverage itself with which to contend. Many of the Obamacare plans I have encountered have significant coverage limitations that then affect the care plan I can realistically implement. Although I make recommendations based on medical necessity and clinical acumen, if the patient cannot or will not pursue my care plan due to coverage issues, I am sometimes forced to alter my treatment plan.

PM: *What types of practice arrangements—i.e., solo, small partnerships or larger super groups—do you favor in dealing with today's economic climate?*

Ornstein: Surely, although certain healthcare environments throughout different parts of the country are conducive to specific practice arrangements, I am certain that all types of practice arrangements can survive and thrive. As founder, and since serving as president and chief operating officer of the New Jersey Podiatric Physicians and Surgeons Group, LLC for the past five years, however, I have had a bird's eye view of the many benefits of a super group. In many instances, and for many highlighted populated regions of the country, super groups are becoming favored by the insurers.

The foundation of super groups is focusing on evidence-based treatment protocols, resulting in the delivery of effective and cost-efficient patient outcomes; and capitalizing on the economies of scale relative to reducing administrative costs and developing ancillary revenue streams, thereby reducing the cost of providing quality care. Thus, while being able to negotiate favorable reimbursement rates with third-party payers and other delivery systems is a fundamental goal of each of these super groups, it is merely one prong in a multi-faceted approach to increasing practice profitability. The collective mantra underlying any negotiation aimed at increased reimbursement on a per service basis is reducing the overall cost on a per patient basis, as opposed to merely demanding higher reimbursement due to market share. Thus, the goal of these super groups is to foster partnerships with payers and other healthcare delivery systems to help achieve better care for patients, while at the same time reducing overall costs.

There are four stages of super group development: the pre-development phase, which includes setting broad goals about what the group hopes to accomplish; the design phase, which entails creating business and operational structures, as well as capitalization and business plans; the documentation phase, which formalizes the plans designed during the prior phase; and the implementation phase, which is where the groups begin operating pursuant to the formal agreements and processes they have put into place. During development, super groups must move towards initiating payer and vendor contacts, while installing internal quality assurance protocols. At the same time, prospective product and service providers should be prepared to cater to the needs of developing super groups in short order, as their go-live dates near.

Hultman: Given the need to do more with less, and do it better, I feel that collaboration among practices will have efficiency and quality advantages that will be difficult for smaller practices to achieve. These advantages include efficiencies of scale, greater clout when negotiating contracts, utilization of common software, adequate staff to handle compliance and complex billing issues, and standardized treatment guidelines that reduce variation and can be objectively measured to show outcomes.

Christina: While the type of practice arrangement physicians may choose takes into consideration geographic location, economic status of the community, etc., in general, a properly run super group will probably offer the best opportunity to take advantage in economies of scale to help control overhead costs. Providers should do a careful analysis and get appropriate legal consultation for whatever practice arrangement they decide to pursue.

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Lehrman: Any of the practice arrangements in question has the ability to be successful if their leaders are doing their homework and keeping up with issues such as the government incentive/penalty programs and preparing for quality-based reimbursement. With proper preparation and planning, any of these practice arrangements can thrive today and in the future. The small partnership is what works best for me, but with preparation and planning, there is no reason why any of these others cannot be successful today.

I believe that if a practice isn't diversified with ancillary services and marketing capabilities, the physician will suffer in the years to come.—Moore

Spector: Actually, I have always favored an employment arrangement as opposed to sole proprietorship in private practice, basically because of my desire to focus as much as possible on clinical care. In this changing environment, I see it getting continually harder to be that sole practitioner. I have colleagues in many different practice scenarios and see struggles with all of them. I have a feeling many of these colleagues will be compelled to become part of larger practice entities over time.

Q ***PM:*** *DPMs are feeling the negative impact of eroding reimbursement rates, greater competition, and increased out-of-pocket patient costs; on the other hand, the surging number of active Baby Boomer patients holds much promise for increased revenue. How do you see these positives and negatives playing out for the profession?*

Moore: With Medicare being the best payer among the rest, physicians taking care of seniors and providing them with a level of superior customer service and care is vital. To that end, eight years ago, I started a balance and fall prevention program in our practice in association with our physical therapy department. We hired a certified orthotist and pedorthist to be able to provide a full array of shoe and bracing options for our seniors. Put very simply, I believe that if a practice isn't diversified with ancillary services and marketing capabilities, the physician will suffer in the years to come. This diversification takes the average practice beyond surgery and routine foot care, and will allow it to thrive going forward.

Ornstein: As an eternal optimist as well as a mentor and advisor to many students, residents, and new and established practitioners, I feel that it is important to

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be pragmatic to deal with the reality—the powerful, hard challenges physicians have. That being said, it is clear that podiatric medicine will continue to be in high demand in healthcare. The trends are real with the increasing number of baby boomers with more active lifestyles than in years past, the many co-morbidities in the aging population, the growing epidemic of diabetes, and the growing class of younger Americans, who regularly exercise in order to proactively avoid the very same epidemic of chronic diseases.

The truth remains that this profession is still relatively small in numbers and the growing trend will be that podiatric physicians will become busier than ever. Many practices in even saturated markets are exploding at the seams with strong income streams. While there may be disparities among practice incomes, it is common to see those on the lower end of the rung being reactive, while those on top being proactive and constantly changing for the better.

Lehrman: The 2016 Medicare Part B Physician Fee Schedule reflected an overall 0.29% decrease from 2015. Even if a doctor collects upwards of $300,000 in Medicare Part B dollars in a year, that results in a decrease of $870 for the whole year. Realistically, that amount can be easily offset by a simple slight change in the efficiency of a practice, or by just treating a couple more patients in one day. The baby boomers that increase the need for podiatric care actually reduce competition among practices and increase the overall demand for podiatric physicians, which is inherently good for the profession. If practices are struggling because the patients are facing increased non-covered, out-of-pocket expenses, I encourage them to re-assess their marketing strategies to ensure they are increasing the number of patients into their practice, and more importantly, that these patients can provide healthy reimbursements to ensure that any increase in costs will be offset by productivity.

Hultman: As previously mentioned, a growing demand is always a good thing because it increases value and provides greater leverage for negotiating contracts. Baby boomers, increasingly active life styles, the rise in diabetes, and costly chronic conditions, all of which are greatly impacted by increased walking, assure that the need and value for podiatric physicians will grow relative to the value provided by other physicians.

Christina: The combination of active baby boomers and the increasing epidemic of diabetes directly related to obesity means the demand for services provided by podiatrists will be extremely high moving forward. This will present great opportunities, but will potentially be tempered by whatever reimbursement method develops in the future. Those who can demonstrate the value of the services they provide potentially have the opportunity to thrive both from payers and having patients pay for services. Much of patient self-pay is dictated by the economics of a practice location but, in the appropriate community, there is the potential that patient self-pay could be very positive for those who provide the highest quality service.

The baby boomers that increase the need for podiatric care actually reduce competition among practices and increase the overall demand for podiatric physicians, which is inherently good for the profession.—Lehrman

PM: *Specialty practice models, from niche and Centers of Excellence (for diabetes, neuropathy, pain management, sports medicine, etc.) to house call and concierge practices, seem to be catching on in healthcare. Do you see some or all of these as good "fits" for podiatry and, if so, what recommendations can you offer to those considering these options?*

Spector: Podiatric medicine plays a significant role in the evolving world of healthcare that, I think, yields a great opportunity for future success. Podiatric physicians can cater to an aging population through making house calls, treating a population of strong healthcare decision-makers through concierge, and practicing by niche through the Centers of Excellence. I think the most important thing is that podiatric physicians stay educated on the medical-legal parameters of each scenario to determine the most appropriate fit.

Moore: I have been lecturing in the AAPPM and across the country on creating Centers of Excellence for over twelve years. This, in my opinion, is the key to practice with the ability to thrive in the future. Diversification, ancillary services, and customer service will be the keys to survival in the years to come. Developing a Center of Excellence isn't easy, but it isn't impossible. It takes investment in services, staff, and technology, but with the right guidance and marketing, podiatric physicians can create a Center of Excellence in areas such as heel pain, balance, diabetes, surgery, dermatology, and pediatrics. I know doctors who have created centers and have achieved great success but, as I mentioned, doing so takes mastery of all of the compliance issues that will arise as well as having the right staff and outstanding service.

Hultman: All of the areas in question, and more, can be good fits for podiatric medicine. There are roughly 300 CPT codes utilized by DPMs, and if some DPMs can make a living in a niche that only utilizes

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a few of those codes, then everyone has the opportunity to focus on the areas of practice they most enjoy and are best at. Actually, this is another good reason for larger groups. Somewhere within the group, there will be a doctor who has an interest and the necessary skills to treat specific conditions for which another member doctor has no interest. Not everyone needs to universally perform rearfoot reconstructive surgery, be good at wound care, or make house calls.

Christina: I, also, think any of these specialty practice models could be good fits. As noted previously, some of this is dependent on the community in which the physician chooses to practice. The key to having a specialty practice is to first do research, and then make sure that there will be a demand for the particular special area of practice to be pursued in the desired practice location. Another caveat is that if referrals are wanted, faithfully keeping to the chosen area of specialization is important so that other referring providers will not be concerned about losing patients in the referral process.

Ornstein: There is a place for all specialty practice models depending on many variables which include: years in practice, training, practice preferences, target income, and demographics such as size of target population, age, and income, to name a few.

Concierge medicine has grown exponentially over the past few years, mostly driven by the load of paperwork, working with insurers, and dwindling reimbursement. A significant percentage of patients overall go out of network with even higher deductibles or to non-participating physicians for the high quality of care they desire and better physician access. The model of concierge medicine supports the fact that with the right framework, one can convert a practice to a concierge model. The foundation of this framework is to have an established reputation in the community and a large patient base, as well as a practice focused on delivering superior customer service.

Concierge medicine has grown exponentially over the past few years, mostly driven by the load of paperwork, working with insurers, and dwindling reimbursement.—Ornstein

The concierge model has proven to work well when soil is fertile for such with the right variables in line as discussed above. A good place to start, if considering this change, is to look at what percentage of overhead would be eliminated with a concierge practice, and how much revenue would need to be produced to have the desired net income. This ultimately sheds light on the cost factor related to processing insurance and all other revenue-consuming related activities. One must accept that with a concierge model, patient volume goes down, thus reducing staff and many other high costs. One should sample some of the patients about how they would feel about this transition, and if they would pay for the concierge services. Evolution to this way of practice can occur over time, integrating more and more out-of-pocket services.

For years, when speaking and writing, I have been a huge advocate for the practice model of a Center of Excellence, where there is a complementary fit between a desired way to practice and the patient population to drive its success. There are many areas of focus, with the most common being wound care, sports medicine, diabetic foot care, and neuropathy. This is not to say that a practice has to do one of these exclusively, as most podiatric physicians who do this already have an otherwise well-rounded practice in the most common conditions. The key for success in the center model is in the packaging and marketing. The packaging involves orienting the office with the focus on the foundation of a particular center, propelled with internal and external marketing. This marketing delivers the primary message to medical and local communities that all services from A to Z with treatment are available, and that office protocols exist to deliver best outcomes and that quality of care is in place to deliver services in the most cost-effective way.

A perfect example of this model would be a practice centering on diabetes. With projected increases in diabetic patients in future decades, now being called endemic, a popular focus has been in the area of diabetes, wound care, and neuropathy. A center can be a combination of focusing on all three areas with the common thread of diabetes, or primarily a focus, say, on wound care or neuropathy. Of course, insurers may be willing to pay providers better with hefty incentives towards the prevention and healing of wounds, limb salvage, and reduced amputations.

PM: *Given the continuing residency crisis, do you feel the profession of podiatric medicine harms newly minted or young practitioners?*

Lehrman: I do not believe that at all. Based on all recent indicators, the residency crisis is improving, and quickly. At its March 2015 meeting, the Residency Review Committee increased the number of approved residency positions to 609 and, in 2015, there were 553 graduates from podiatric medical schools. The goal was to have the number of positions available be 110% of the number of graduates. The figure now stands at 108%, so there are enough residency slots for the number of students who are graduating. The problem is that there are still 60-something graduates from previous years who need to be placed. Once these graduates are

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placed, the crisis will be over. With the current surplus of residency positions, that should not take long at all. The true crisis, on the other hand, is in the declining applicant pool. Efforts need to be concentrated on not only increasing the number of residency positions, but also on student recruitment to increase interest in podiatric medicine and the applicant pool to the schools.

Hultman: While it may be true that the residency crisis is lightening at this time, a potential problem remains. This is the closure of a program that does not have a resident. I don't agree that the specialty of podiatric medicine and surgery harms our young practitioners. When we look at the economic environment into which new practitioners will be entering, we see that it is marked by growing demand, a declining supply, a large number of podiatric physicians nearing retirement age, and an increasing number of podiatric groups that are dependent on attracting well-trained, newly minted practitioners to meet demand in order to continue growing. If anything, one could argue that today's new practitioners are actually in the drivers' seats.

Christina: I do not believe that the profession harms young practitioners, but just the opposite. The adoption of the standardized three-year medicine and surgery post-graduate training program has granted these young practitioners access to both recognized certifying boards, thereby giving them an easier entré into hospitals and insurance companies.

Moore: I believe what hurts new practitioners more than anything is the complete and utter lack of real life practice management tools offered to them in residency. It seems that this profession is doing a great job of creating orthopedic surgeons, but trains too few residents in the casting and prescription writing for an AF, for example. It seems as though more and more residents are being sent out into practice without some of the most important management and business skills necessary to grow practices and provide a diversified comprehensive level of podiatric medicine.

Ornstein: A great advantage that established doctors have is the ability to hire associates right out of residency who lack knowledge on aspects of practice, especially coding and billing. Obviously, this lack of knowledge can heavily affect the bottom line of a practice. For those unfortunate students who have not matched, this is an opportunity to increase their marketability, and work in podiatric medical offices during re-application for a residency. They can get the opportunity to learn the lay of the land in real life podiatric medicine, which makes them more attractive applicants in subsequent years.

I was involved with starting the Office Mentorship Program five years ago. It was designed to match those who did not get a residency with a practicing podiatric physician. The recent graduates would work in the podiatric medical office for a year and the practicing physicians would serve as mentors. Although most states do not allow unmatched graduates to function any more than as office assistants, this was still a very valuable chance to become familiar with all aspects of practice. Approximately half those who did not match have done the mentorship since its inception, with almost all getting a residency the year after. In addition, these new doctors ended up getting top associate positions since they had that one year of being in the trenches of a practice.

Q ***PM:*** *Payers, primarily led by CMS, are moving rapidly to replace fee-for-service for alternative payment models. How do you see DPMs fitting into the evolving model of healthcare reimbursement?*

Lehrman: The alternative payment models referred to here reward quality care and value care that is efficient to the healthcare system. Podiatric medicine defines these criteria. The Thomson Reuters Study, "The Economic Value of Specialized Lower-Extremity Medical Care by Podiatric Physicians in the Treatment of Diabetic Foot Ulcers" suggested that if all diabetic patients insured with commercial and Medicare insurance plans had a pre-ul-

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cerative visit to a podiatric physician, $1.97 billion could be saved among those with commercial insurance in one year and $1.53 billion could be saved among those with Medicare insurance in one year.

A similar study done at Duke University showed that patients who visited a podiatric physician and/or a lower-extremity clinician specialist within a year before developing complications were between 23 percent and 69 percent less likely to have an amputation. These amputations are incredibly costly and otherwise expensive to the healthcare system, and the ability of podiatric physicians to prevent them carries tremendous value. Podiatric physicians are well positioned to thrive in an environment that rewards quality, cost-saving care.

Hultman: Realistically, until payers can truly measure outcomes, none of the quality measures in use to date are going to make much of a difference in the quest for quality improvement. Rather, they will only serve as a reason for third party payers to cut payments for those who are not able to check off all the quality boxes. The primary quality measure to focus upon, one that assures success and inclusion in whatever healthcare system materializes in the future, is patient satisfaction and patient feedback to physician and health plan referral sources. Until all doctors are on EMRs that communicate with one another and are able to compare the outcomes of various treatment protocols, there will be no improvement in the kind of quality that matters.

Christina: First, it is important to point out that even the change to the merit-based incentive payment model (MIPS) is still based on fee-for-service; what will vary is the amount plus or minus that one can earn. DPMs can fit into the alternative payment models, but it will take work for all specialists to carve a place in accountable care organizations or alternative payment models that utilize an episode of care-type reimbursement model.

Moore: Despite all the on-going changes, I am keeping my focus on having the Center of Excellence in my community that can provide great care and great customer service. In that way, I think no matter how it all shakes out, my practice will be fine.

PM: *Given today's healthcare challenges, do you favor a degree change from DPM to MD in an effort towards parity?*

Hultman: MDs and DOs have different degrees, but they hold the same license. I am on public record stating that parity can be achieved when DPMs hold the same plenary license as MDs and DOs, in other words, MD = DO = DPM. The problem with the discussion of changing to an MD degree is that it is just a discussion. Other than going to medical school and receiving an MD degree, I have yet to see a credible plan proposed by anyone that would result in the DPM degree being changed to an MD degree. There is, however, a credible plan that has been in process for the past four years in California to demonstrate equivalency of training and education. This plan is fully capable of achieving a goal of DPMs receiving the same license as MDs and DOs. This plan entails site visits to California podiatric medical schools and residency programs, and it is overseen by a Joint Task Force whose members include representatives from the California Medical Association, the California Orthopedic Association, the Osteopathic Physicians and Surgeons of California, and the California Podiatric Medical Association, along with participation by the college deans and consultants who have LCME and ACGME expertise. To reiterate, this plan does not involve a degree change; instead, it is a license change, from a limited to a plenary license, yielding the same Physician and Surgeons Certificate held by MDs and DOs.

Christina: There is no simple way to convert from a DPM degree to an MD degree. Essentially, to get an MD degree, one needs to graduate from an accredited allopathic medical school (accreditation done, by the way, through the LCME). I think our current education and post-graduate training, that of standardized three-year residency programs through a natural process, will allow a change in how the profession is viewed. Eventually the recognition by all will be that podiatric physicians are physicians on par with MDs and DOs, which will ultimately be reflected in licensure. For podiatric medicine to continue to exist, I believe, so should the DPM degree.

A credible plan has been in process for the past four years in California to demonstrate equivalency of training and education. This plan is fully capable of achieving a goal of DPMs receiving the same license as MDs and DOs.—Hultman

Lehrman: Simply put, podiatric physicians chose this field for a reason. Rather than try to change the identity, I feel podiatric physicians should take pride in their work and advocate for their own rights as physicians. In keeping with parity, podiatric physicians should absolutely strive for parity in reimbursement. I strongly feel that a podiatric physician should be reimbursed the same as any other specialist for doing the same procedure. Parity, however, must come with care not to overstep scope of practice. This is not necessarily degree-specific, but rather specialty-specific. For example, I believe only certain medical specialties should be empowered to do histories and physicals on patients with med-

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ical conditions prior to having major surgical procedures, not necessarily podiatric physicians, or orthopedic or plastic surgeons for that matter.

PM: *All things considered, despite the obvious changes in healthcare, what elements of podiatric practice do you feel will remain the same and should be emphasized in order for practices to remain successful? How do routine foot care, biomechanics, and surgery fit into this future scenario?*

Spector: Ultimately it's the passion for and commitment to patients that should remain the same for all podiatric physicians as premier foot and ankle experts. I believe podiatric physicians should find their respective niches for both marketing and finding places in even greater healthcare entities. Routine foot care alone cannot sustain typical podiatric practices, but along with experience and ability in biomechanics, orthotics, wound care, and much more, podiatric physicians will always remain important members of the multidisciplinary healthcare team.

Moore: Diversification and comprehensiveness are the keys, and I strongly feel like these will be the keys to the survival of podiatric medicine. Yet, in the same breath, it seems as though podiatric medical residents are training to be fairly one-dimensional surgeons—albeit very good surgeons, but in some cases, with little other expertise. I hope this can change over time, as surgery reimbursement continues to dwindle and other biomechanical-related service reimbursement continues to flourish.

Lehrman: The change in reimbursement being tied to quality is an excellent one for podiatric physicians. As mentioned earlier, there are studies attesting to the proven value podiatric physicians provide to the healthcare system. The same excellent care that has always been provided will bode well for podiatric physicians in the future. For instance, at-risk foot care will always help to prevent ulcers and amputations, contributing long-term cost savings to the healthcare system. Biomechanics that can improve the quality of life of patients and, in many instances, can prevent falls and other adverse events, will also continue to carry value. It remains to be seen, however, how surgery will be valued and how it will fit into a quality-based reimbursement model. Fortunately, the equation for a practice to be successful will not change even as the reimbursement model changes.

Christina: As stated before, the demand for services that podiatric

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physicians provide will only continue to increase. Reimbursement models may change, but the value that is brought to providing care for the population will still exist and, in fact, the need will increase. I think there is a misconception that the profession is only training surgeons with our standardized three-year medicine and surgery programs. The fact is that podiatric residents are being trained with the opportunity to pursue however they want to structure their practices. Some will find palliative foot care is still something they choose to provide, while others may be drawn to biomechanics, some to wound care, and some to surgery. The beauty of standardizing training means that podiatric physicians have the opportunity to take their careers in podiatric medicine in the direction of their choosing, without barriers.

Ornstein: It is evident that as the landscape of our healthcare changes, there will be modifications necessary to all subspecialties. One of the unique aspects of podiatric medicine and surgery is the ability to keep patients active and healthy and prevent amputation. This is of paramount importance since the population is continuing to age. One thing that has been demonstrated is that our current healthcare delivery system is wonderful at acute care management and horrible at long-term chronic care management.

I feel this scenario offers a keystone opportunity for this profession. With fine training and understanding of the complexity of systemic disease management and its effect on lower extremities, podiatric physicians have the ability to keep the aging population healthy and active. The ability to provide comprehensive lower extremity management to this aging population signifies the podiatric physician role as the primary care physician of the lower extremity. All aspects of podiatric medicine come into play. This includes patient education, preventative measure programs, quality assessment, appropriate quality measures, and treatment protocols.

From a clinical perspective, preventative care treatment programs are of extreme importance. Preventing a small fissure on a vascularly compromised limb can avoid an episode of cellulitis, hospitalization, and possible untoward complications. No other group of specialists are positioned to prevent this type of event.

An understanding of biomechanics to facilitate improved ambulation is another important component in keeping a patient active and healthy. Identifying a drop foot, which is easily treated with a dorsal assist brace, can prevent a fall, potential fracture of the hip or other body part, which could be life-altering in an elderly individual.

Appropriate surgical intervention to address structural abnormalities, which could create pain, tissue breakdown, or other clinical complication is another valuable tool within our toolbox.

Hultman: When patients experience foot and ankle pain or have difficulty walking, they are almost always hoping there is a solution other than surgery. Podiatric physicians should have the widest possible range of both surgical and non-surgical treatment options available to patients because that will lead to the best outcomes. While routine foot care, biomechanics, and surgery fit into the future, the treatment options open to DPMs is expanding even more. When I graduated, very little was being done in areas such as sports medicine, wound care, fall prevention, etc.

I think there is tremendous opportunity in getting and keeping patients walking. In addition to reducing pain and improving function, increased walking should be an additional outcome of everything done by podiatric physicians. Given that some of the most costly conditions in healthcare (i.e., obesity, diabetes type II, osteoporosis, stroke, ischemic heart disease, hypertension, and dementia) are prevented by or are improved with walking, DPMs should be highly valued in a future that is actually able to measure treatment outcomes for these conditions. **PM**

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