MOVING INDIANA FORWARD

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INDIANA PODIATRIC MEDICAL ASSOCIATION

Forward

ISSUE ONE | SPRING 2018

IN THIS ISSUE

PRESIDENT'S MESSAGE

WENDY WINCKELBACH, DPM | IPMA PRESIDENT

I am excited to begin my term as President of the IPMA. I believe the IPMA is in a strong position entering 2018. We have a tremendously experienced Board of Trustees serving the interests of the IPMA membership. Additionally, we have recruited young members with the goal to cultivate new leadership. If you are interested in joining a committee or getting involved, please do not hesitate to contact me or the IPMA office. To remain a strong organization, the IPMA truly needs your time and talents.

In 2017, the IPMA finished the fiscal year with a profit of slightly more than $7,000. This is the sixth straight year with a profit and will put IPMA's rainy day fund over $100,000.

Additionally, in 2018 the IPMA member incentive program will be in full force. If you have taken advantage of all aspects of the incentive program, you will be eligible for a $100 fall convention this year in Indianapolis. Year in and year out, the IPMA Board hears that the lectures given at the IPMA Annual Convention are better than those they receive at the Midwest Podiatry Conference. We hope that you all will take advantage of that fact and attend.

Please mark your calendars for the following events:

- **Midwest Podiatry Conference:** Hyatt Regency, Chicago, IL, April 19-22
- **The National 2017 Scientific Annual Meeting:** Gaylord National Resort & Convention Center, National Harbor, MD, July 12-15
- **IPMA Annual Convention:** Hyatt Regency Downtown, Indianapolis, IN, October 18-21.

If you have any thoughts, concerns or suggestions regarding the activities of the IPMA, please do not hesitate to contact me.

NEW ONLINE LIMITED PODIATRIC RADIOGRAPHY EDUCATIONAL PROGRAM

The Indiana State Department of Health (ISDH) requires all podiatric medical assistants who take x-rays to be licensed as a limited podiatric radiographer.

The IPMA wants to remind the membership of its new limited podiatric radiography program that meets the ISDH requirements and is designed to instruct the podiatry assistant in the safe and effective use of x-rays in the podiatric practice.

Content includes:

- History of the x-ray
- Risks and safety measures associated with radiography
- Image production and film development
- Principles of CT Scan, MRI, and Bone Scan
- Anatomy of the foot and ankle
- Positioning and x-ray machine placement

PROGRAM STRUCTURE

The program consists of four online content modules, each with a final exam, one attestation module, a student manual, and an x-ray log. A Certifying Physician must guide the applicant in the clinical portion of the program and the completion of the x-ray log. The podiatry assistant must document competency by demonstrating the proper performance of 60 x-ray views in the podiatrist's office.

At the successful conclusion of the program, the applicant will have the proficiency and skill necessary to obtain the limited podiatric radiography license and will receive a Certificate of Completion. The Certificate, the completed Application for Proficiency Certification for Limited Radiographer and signed x-ray log should be sent to the IPMA.

Please contact the IPMA office with any questions at 888.330.5589.

APMA HAS SAVED ME HOW MUCH?

APMA provides tangible benefits for your dues dollars, but your association's advocacy efforts also *save* you thousands of dollars—if not more—each year. Just two of APMA's recent initiatives have saved members more than $100 million.

APMA spearheaded a massive effort to prevent the implementation of a proposed CMS rule that would have changed certification requirements for podiatrists furnishing and fabricating prosthetics and custom orthotics. The rule would have required previously exempted, qualified practitioners to obtain additional certification and licenses to furnish and fabricate prosthetics and orthotics. Those certifications would have required periodic examination, at a cost of thousands of dollars (in addition to travel costs). The proposed rule was withdrawn after a massive and multifaceted advocacy effort from APMA.

APMA has also achieved a significant victory at Anthem, where an onerous policy would have significantly cut reimbursements for evaluation and management (E&M) services billed with CPT modifier 25 when reported with a minor surgical procedure code or a preventive/wellness exam. APMA's efforts, spearheaded by Frank Kase, DPM, member of the Health Policy and Practice Committee and Private Insurance Subcommittee, have delayed (and perhaps even mitigated) the policy, and Anthem has agreed to reduce its initial decrease by half. We are still in vigorous discussions and hope to eliminate the policy altogether, but the delay and the modification have effectively saved APMA member podiatrists approximately *$100 million per year.*

BRINGING GREAT PRACTICES AND TALENTED PROFESSIONALS TOGETHER

To be successful, job boards must connect with two core audiences: job seekers and employers. The AAPPM is pleased to bring you its Job Bank, a web-based job board that brings both job seekers and employers together for the podiatric profession.

The AAPPM is also proud to make this resource available to the entire podiatric profession. You do not have to be an AAPPM member to take advantage of this resource!

Are you hunting for a new job? Or perhaps you are moving to another state. Are you an employer searching for your newest employee? Start your search today with the AAPPM Job Bank. Post your job opening, post your resume, browse for jobs, or browse potential employees.

VISIT AAPPM.ORG/JOB-BANK TO GET STARTED.

AN UPDATE ON THE APMA REGISTRY

APMA appreciates members' great interest in the APMA Registry. Please make note of the following:

- If you registered to use the APMA Registry for the 2017 performance year, you will receive instructions regarding login and use of the registry shortly.
- We continue to process business associate/data use agreements and will let you know if we need further information from you.
- You have until March 24, 2018, to use the APMA Registry to attest to CPIA and ACI measures.
- If you are a MediTouch user, we will let MediTouch know your intention to use the APMA Registry for the 2017 performance period.
- The APMA Registry will be open for 2018 performance period registration shortly.

PQRS	NQF	Title	NQS Domain
110	0041	Preventive Care and Screening: Influenza Immunization	Community/Populati Health
111	0043	Pneumonia Vaccination Status for Older	Community/Populati
126	0417	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral	Effective Clinical Care
127	0416	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer	Effective Clinical Care
128	0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and	Community/Populati Health
154	0101	Falls: Risk Assessment	Patient Safety
155	0101	Falls: Plan of Care	Communication and Care
226	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation	Community/Populati Health
317	-	Preventive Care and Screening: Screening for High Blood	Community/Populati Health
-	-	Comprehensive Diabetic Foot Examination	
-	-	CDR 2: Diabetic Foot Ulcer Healing or Closure	

MINIMIZING RISKS

ASSOCIATED WITH SCOPE OF PRACTICE FOR ADVANCED PRACTICE PROVIDERS

Healthcare is changing rapidly, and the interplay of numerous factors has resulted in a growing need for more healthcare providers in both primary and specialty care. A study commissioned by the American Association of Medical Colleges notes that the United States will face a shortage of between 40,800 and 104,900 physicians by 2030. The driving forces behind this shortage, according to the study, are population growth and the aging U.S. population.

Fast-paced changes in healthcare and increasing demands on doctors have necessitated the consideration of new frameworks and models for the delivery of care. At the forefront of this shifting paradigm are advanced practice providers (APPs) — such as nurse practitioners and physician assistants — who are helping fill gaps in provider availability and accessibility.

APP scope of practice is complex and evolving; thus, it represents a liability concern for healthcare practices and organizations utilizing these providers. However, various proactive strategies can help address scope of practice risks and potentially minimize liability:

- Research state statutes and regulations governing APP scope of practice to develop a clear understanding of what functions these providers are legally permitted to perform. Routinely monitor for changes in state laws related to scope of practice.
- Understand state requirements for collaboration, supervision, and the development of written guidelines and protocols for each type of APP in your organization.
- When developing guidelines related to APP scope of practice within your organization, make sure you fully understand the nature of APP advanced practice, clinical training, and education.
- Ensure that guidelines and protocols specifically define situations that should trigger consultation with the supervising doctor and appropriate methods of communication between providers.
- Routinely review guidelines and protocols to ensure they are current and relevant to APP practice and consistent with state laws and organizational policies.
- Delineate each APP's scope of practice in his/her collaborative agreement or employment contract. Use terminology that is consistent with the language that appears in state laws and practice acts.
- Confirm through oversight and supervision that APPs have the competencies included in their scopes of practice.
- Educate staff about APPs' roles within the organization so that staff members can provide patients with adequate and correct information.
- Make sure patients are aware of who is providing their care and understand their provider options.

IN MEMORIAM: HARRY GOLDSMITH, DPM

APMA is deeply saddened by the passing of Harry Goldsmith, DPM, on February 7 after a battle with cancer. Dr. Goldsmith was a noted coding expert and a consultant to the APMA Health Policy and Practice department. His vast knowledge of coding was instrumental in the development and evolution of the APMA Coding Resource Center, and he supported APMA's RUC and CPT initiatives, committee activities, and other efforts. Dr. Goldsmith was also a longtime delegate to the APMA House of Delegates, at one time chairing the Resolutions Subcommittee.

Dr. Goldsmith was a consultant to many national third-party payers, including Medicare (Southern California), Blue Cross of California, managed care companies, and unions/trusts. He was a noted lecturer and author on topics of managed care, reimbursement, coding and billing, practice management, and fraud and abuse. Dr. Goldsmith was CEO of Codingline, an online forum specializing in foot and ankle coding, reimbursement, and practice management. He was also a consultant to PICA and individual practitioners and groups.

Dr. Goldsmith was passionate about podiatry. He was a mentor to countless physicians, and his presentations at various events were eagerly anticipated—and marked by his signature wry sense of humor. He was a member of the Podiatry Management Hall of Fame and recipient of too many accolades and awards to name here.

"Harry will be deeply missed," said APMA Executive Director and CEO James R. Christina, DPM. "He was not only a valued expert, he was a personal friend and confidant and a true friend to the profession, his peers, and the APMA staff."

Dr. Goldsmith attended the Ohio College of Podiatric Medicine (now Kent State University College of Podiatric Medicine) and practiced podiatry in California before devoting himself full-time to consulting. He was certified by the American Board of Foot and Ankle Surgery (administrative diplomate), a Certified Surgical Foot & Ankle Coder, a member of APMA, and a fellow of the American College of Foot and Ankle Surgeons.

Dr. Goldsmith is survived by his wife, Susan; sons Brian, Mark, and Jon Goldsmith, DPM, and their families; as well as two brothers. A small, private service was held in his memory on Friday, February 9. You may make a donation to the APMA Educational Foundation in Dr. Goldsmith's memory by visiting www.apma.org/donate.

SAVE THE DATE

IGNITE YOUR SPARK

April 19th - 22nd

HYATT REGENCY, CHICAGO

IGNITE

IGNITE YOUR SPARK
AT THIS YEAR'S
MIDWEST PODIATRY CONFERENCE

Registration opens January 1st!

Earn up to 32 CE's while selecting sessions that interest you from tracks that highlight various disciplines and specialties!

Here are just a few things you can look forward to:

Attend hands-on workshops and labs to enhance and sharpen your skills.

Select from 2 DPM tracks to build an agenda that fits your educational goals

New world-renowned speakers and topics

Prepare for ABFAS Certification with our Board Review Course

Continuing education tracks for administrative and clinical assistants

Panels that explore multi-disciplinary approaches to treatment

Connect with our 200 exhibitors to view the newest products, services, and innovations

MUCH, MUCH MORE!! Stay tuned for updates and announcements

midwestpodconf.org • (312) 427-5810

US DEPARTMENT OF JUSTICE ISSUES TWO MEMORANDA THAT LIMIT FALSE CLAIMS ACT LITIGATION

BY BRANDON SHIRLEY AND LAUREN SORRELL
KRIEG DEVAULT LLP

The United States Department of Justice ("DOJ") authored two internal memoranda that effectively limit the kinds of whistleblower actions that can be brought against health care providers for alleged violations of the False Claims Act ("FCA"). Those two memoranda are commonly referred to as the Granston Memo[1] and the Brand Memo[2]. These memoranda were recently published and their impact FCA litigation has yet to fully understood or assessed.

GRANSTON MEMO

The Granston Memo, dated January 10, 2018, reflects a significant policy change regarding the DOJ's election to dismiss certain *qui tam* (whistleblower) lawsuits in which the Federal government ("Government") declines to intervene. The Granston Memo notes that the number of ***qui tam*** actions filed under the FCA has dramatically increased over the past several years, while the number of cases in which the Government has intervened has remained relatively stable. The Granston Memo encourages DOJ attorneys to evaluate whether going one step further and seeking dismissal of the lawsuit may better serve the Government's interests. This is a step that the Government has rarely taken in the past.

The FCA authorizes the Government to dismiss a *qui tam* lawsuit, even over the relator's objection. See 31 U.S.C. § 3730(c)(2)(A). However, the FCA does not set forth specific grounds for dismissal. One purpose of the Granston Memo is to provide a list of factors that the DOJ may consider as a basis for dismissal of a quit tam lawsuit:

- **Curbing meritless *qui tam* lawsuits:** The DOJ should consider moving to dismiss when an action is facially lacking merit or when, after concluding its investigation of the relator's allegations, the DOJ concludes that the case lacks merit.
- **Preventing parasitic or opportunistic *qui tam* lawsuits:** The DOJ should consider dismissal when an action duplicates an existing government investigation and adds no assistance or useful information to that investigation.
- **Preventing interference with agency policies and programs:** The DOJ should consider dismissing an action when it threatens to interfere with an agency's policies or the administration of an agency's programs.
- **Controlling litigation brought on behalf of the United States:** The DOJ should consider dismissal when it would protect the government's litigation prerogatives or ability to pursue or settle ongoing actions.
- **Safeguarding classified information and national security interests:** The DOJ should consider dismissal when doing so could safeguard classified information or lower a risk to national security, particularly in those cases involving intelligence agencies or military procurement contracts.
- **Preserving government resources:** The DOJ should consider dismissing an action when the government's expected costs (e.g. costs of monitoring or participating in ongoing litigation or of responding to discovery requests) are likely to exceed any expected gain.
- **Addressing egregious procedural errors:** The Department should consider moving to dismiss if there are problems with the action that make it difficult for the government to conduct a proper investigation.

The Granston Memo notes that the DOJ may rely on multiple grounds for dismissal and that the factors listed above do not constitute an exhaustive list. Additionally, it may be appropriate in certain situations for the DOJ to seek partial dismissal of some defendants or claims. The Granston Memo notes that

the government will collect information on an annual basis regarding the number of *qui tam* actions dismissed upon motion by the United States. This will allow commonly targeted industries to monitor the new policy and the extent to which it is applied in the future.

BRAND MEMO

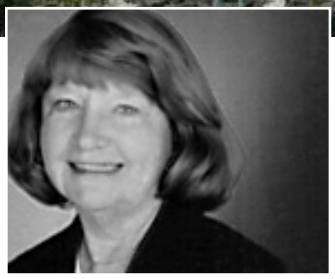
The Brand Memo, dated January 25, 2018, also sets limiting criteria on the types of authorities the DOJ may rely on to support a FCA violation. The Brand Memo specifically concerns the use of agency "guidance documents" as means of demonstrating violations of federal law in Affirmative Civil Enforcement cases, i.e., actions by the United States to recover Government funds lost as a result of fraud, which could include fraud against the Medicare or Medicaid programs. In essence, the Brand Memo recognizes the pervasive use of guidance documents by Federal agencies that are not law but are intended to bind regulated entities or persons. The Brand Memo acknowledges that such guidance documents are not legally binding unless supported by a law or regulation, and as such, directed DOJ attorneys not to convert agency guidance into binding rules or use a person's noncompliance with such as a basis for prosecuting Affirmative Civil Enforcement actions.

The Brand Memo raises many questions over its application in FCA litigation and concerning a health care entity's regulatory compliance obligations. For instance, a recent United States Supreme Court ruling ("Escobar") set standard for FCA liability that focused on whether a given requirement was "material" to the Government's decision to pay a claim. The Brand Memo's shift away from agency guidance documents for establishing FCA violations suggests that only federal regulations or laws should be used when determining whether compliance with a certain requirement is "material" to the Government's decision to pay a claim. Another example, Federal law requires health care providers to report and return Medicare or Medicaid overpayments, typically occurring when a provider or entity receives a payment inappropriately, within 60 days of identification. The issue is whether and to what extent violating a requirement in an agency guidance document is a sufficient basis for establishing an overpayment.

The impact of these memoranda on FCA prosecution or an entity's compliance program is still uncertain. If you have any questions about these memoranda or how to restructure your compliance programs, contact Brandon Shirley at bshirley@kdlegal.com or Lauren Sorrel at lsorrel@kdlegal.com.

1 See Factors For Evaluating Dismissal Pursuant to 31 U.S.C. § 3730(c)(2)(A) (Jan. 10, 2018). Available at https://assets.documentcloud.org/documents/4358602/Memo-for-Evaluating-Dismissal-Pursuant-to-31-U-S.pdf.

2 See Limiting Use of Agency Guidance in Affirmative Action Civil Enforcement Cases (Jan.25, 2018). Available at https://www.justice.gov/file/1028756/download.



LEGISLATIVE REPORT

BY GLENNA, SHELBY, JD, PARTNER
LEGISGROUP PUBLIC AFFAIRS, LLC

Governor Eric Holcomb has called a special legislative session for "mid-May" to give the Indiana General Assembly the opportunity to revive some of the five bills that died in the chaotic closing hour on March 14th, the statutory final day for a "short session". Those bills included the federal Internal Revenue Code update, an annual bill matching (or de-coupling) Indiana's tax laws with federal tax laws; a school safety bill; autonomous vehicle regulation; take over of two "failing" school systems; and another local administration/tax bill.

All had been in negotiations to resolve differences between House and Senate-passed versions of the bill—negotiations that at times were contentious.

Despite having "super-majorities" in both chambers, the time ran out before the conference committee reports on these five bills could be adopted in the House. The Senate did adopt four of the five, but passage requires both chambers to pass the conference committee report.

In his announcement the Governor indicated he wanted the special session to deal only with the school safety bill, the IRS update, and a $12-million loan to the Muncie school system that was in the school take-over bill. However, once the special session starts, any number of bills can be introduced and only House and Senate leadership can exercise control over the bills filed. It's expected the special session will last only a few days, but because the 2018 session statutorily ended at midnight on March 14th, the legislative process begins anew — bill filing, committee hearings, second reading, third reading in the first chamber and the same process in the second chamber. Rules can be suspended to shorten the time period between the "steps".

Despite the contentious conclusion, 212 bills did pass this session — that's out of just over 900 introduced.

While Sunday carry-out alcohol sales and workforce development issues grabbed many of the headlines, there are other bills of relevance that did pass and have been or are expected to be signed by the Governor.

HB 1130 contained numerous "clean up" provisions to various professional licensing statutes, including provisions recommended by the PLA to the now-repealed Job Creation Commission. It repeals the sections establishing a podiatric assistant's license, which was never implemented in over 20 years of being "on the books"; authorizes the Board of Podiatric Medicine to approve a licensing exam rather than stipulating

a particular exam; conforms reinstatement provisions within the DPM licensing law with the general PLA reinstatement provisions; and requires that information regarding addiction treatment, physical injury or disease, or mental health issues that may affect the ability to practice within the prior two years be reported at renewal (current law is prior 4 years). Language once in the law repealing existing reciprocity standards was removed at the request of IPMA.

HB 1143 specifies requirements for prior authorization of health plan coverage and claims payments. It requires notice be posted on a plan's website and for electronic transmissions of requests and plan responses with exceptions for areas with poor Internet services and when a provider has too few plan-covered patients to justify the cost of compliance. Most provisions in HB1143 are effective after Dec. 31, 2019.

HB1175 requires the Departments of Health and Family and Social Services to develop a strategic plan to identify and reduce the prevalence of diabetes and prediabetes.

HB1191 removes the requirement that a licensed health practitioner report that an adult patient is a suspected victim of human trafficking to local law enforcement, and instead requires the practitioner to provide information concerning available resources and services to a patient suspected to be a victim of human trafficking.

HB1245 contains multiple provisions relating to state/local occupational licensing. A late amendment includes language once in another bill detailing the notice a provider must give to a patient to whom a telephone referral to another provider is made—cautioning that the other provider may not be in the patient's network. The referring provider is required to make note of the referral in the patient's medical record.

SB52 authorizes the retail sale of low THC hemp extract (not more than .3% THC), provides for testing, packaging, and labeling requirements.

SB221 contains staggered deadlines for opioid prescribers in various practice settings to check INSPECT before prescribing a patient an opioid or benzodiazepine to the patient. Beginning Jan. 1, 2019, requires a practitioner who is permitted to prescribe a controlled substance must be certified to receive information from the INSPECT program, allowing for a waiver if the practitioner doesn't have Internet access available.

SB223 requires certain licensed healthcare professionals (MD's, nurses, dentists, physician assistants, and pharmacists) to provide various workforce information to the Professional Licensing Agency when renewing their licenses. DPM's are not included in the requirement.

SB225 requires 2 hours of continuing education on opioid prescribing and opioid abuse during a 2 year period for every licensed practitioner applying for controlled substance registration. The 2 hours are included within any currently required hours, not in addition to current requirements.

SB369 prohibits Workers' Comp reimbursement for drugs specified in the ODG Workers' Compensation Drug Formulary Appendix A published by MCG Health as "N" drugs.

SB431 provides immunity from civil and criminal liability for a health care provider who provides professional intervention in an investigation of the Department of Child Services resulting from a report that a child may be a victim of child abuse or neglect.

Also, HR 2 passed, seeking a summer study committee on the subject of medical marijuana.

SB 399 was defeated in the House following successful lobbying by a coalition of professional associations including IPMA. It would have required all licensing regulations be reviewed by the Small Business Ombudsman with the aim of providing the "least restrictive possible" regulation of professions and occupations, including no regulation where possible.

These and all bills introduced in the 2018 session can be found at http://iga.in.gov/legislative/2018/bills.

SECRETS OF SUCCESS PART II OF II
WHO AND WHAT IS KILLING YOUR PRODUCTIVITY?

BY LYNN HOMISAK
SOS HEALTHCARE MANAGEMENT SOLUTIONS

Still fighting off those negative forces that work to prevent you from practicing as productively as you can?

Overlooking poor performing staff?

- *"(S)he's been with me since I started! I can't let her go!"*
- *"Sure, the other staff are having difficulty getting along with her/him, but I just tell them to deal with it. They don't have to go home with her/him."*
- *"I could never replace him/her...(s)he's the only one that knows my practice inside and out!"*

This problem is very commonplace. If you are not among those who feel stuck in the middle between say, a longtime employee/manager and the rest of the staff, consider yourself lucky. To be clear, poor performance is legally defined as 'when (any) employee's behavior or performance (duties of their role) might fall below the required standard'. That in itself is enough to warrant a discussion – likely some additional guidance, possibly a write up. What's worse is when doctors fail to recognize the cultural as well as the occupational damage that these employees have on the practice and make excuses for them to "carry on" in spite of it – resulting in the loss of good staff, ongoing disruption from frequent staff turnover, a plummeting morale, and an unhealthy dose of resentment towards management for not putting their foot down and taking charge. Of course, it's when there is no policy in place or certain people appear to be exempt from following the set rules and regulations that things get out of hand. Every practice should have an employee manual that states such rules – including a clearly outlined disciplinary policy to make sure that they are carried out fairly across the board. No exceptions. Policy avoiders get very good at what they do – if they are continuously allowed to get away with it!

POOR TRAINING

Over my professional lifetime, I think I've managed to write about why trained staff are so critical to the success of a practice more times than I could count. If my message isn't out there by now, it never will be! Typically, the perfect, omniscient employee doesn't just walk into an office and get everything right from the start. Yes, you should always shoot to hire the best, but even they need to be re-trained to some degree and learn to adapt to new methods, people, policies and apparatuses. Rest assured, the only staffer who winds up being worth his or her weight in gold has been given the proper time, training, knowledge, tools and leniency to get to where they are. And if you play your management cards right, you may even convince them to stay with you until the day you retire. At least, that should be your HR goal.

INEFFECTIVE WORKSPACE

Focusing not so much about the number of rooms you have, as much as how they are arranged, the layout and ease at which you and your staff can work in them. Most frequently used equipment should always be within reach. Staff who must run to another room to fetch something they printed are wasted steps, not to mention time-consuming. The design of the front desk area should be ergonomically correct to allow staff to work comfortably, safely and to avoid fatigue. For example, chairs and computers should be at the right height (eye level), the right distance (to avoid screen glare) and have arm rests to avoid shoulder strain. The layout of each treatment room should be similar (preferably identical) to each other – as should the organization of supplies in each cabinet drawer. Taking a picture of each drawer for the procedure manual helps staff follow through accordingly.

WRONG POSITIONING OF STAFF

It's surprising how many people take a job just to have a job (and a paycheck) even though their heart is really not into it. In fact, just last week, during one of my on-site consultations, I noticed the receptionist was frustrated at the front desk and made a point of speaking with her. We talked a little about what was troubling her and she didn't much complain. It was only after I asked her how she liked her job, that I learned she wasn't really happy. "I applied for the job here as a receptionist, but it's not really what I enjoy doing," she said. "I went to school and was trained to be a medical assistant. I only took this job because there were no openings for an MA and thought sooner or later, a position would open where I could put my learned skills to use. Unfortunately, I'm still sitting here, two years later!" Staff should be hired and positioned according to their strengths and skills; otherwise you can expect a less than enthusiastic employee putting in a less than enthusiastic effort and resulting in a less than desirable outcome.

Not every topic mentioned in this two-part article may be immediately doable in your office, so maybe just start by taking one or two…or three that will!

APMAPAC REPORT

BY CHRISTOPHER GRANDFIELD, DPM AND PATRICK A. DEHEER, DPM

We are proud to report that IPMA members have stepped up again and contributed 107% percent of IPMA's fundraising goal for 2017. This means the IPMA has hit its goal for the fourth consecutive year. Indiana is the only State Component with over 200 members to reach its APMAPAC fundraising goal!

Now begins the 2018 fundraising campaign. This year the IPMA fundraising goal is $18,020. As everyone is aware, Washington DC is undergoing drastic political change and the APMA needs to be at the table during this time. The APMAPAC is a critical tool to ensure that happens.

We ask all members to strongly consider a recurring monthly contribution of $20. This allows members to make a meaningful contribution while avoiding the necessity of writing one large check. As of March 1, 2018, these IPMA members have pledged their contributions to APMAPAC:

DIAMOND LEVEL SUPPORTERS ($2,500-$4,999)

Dr. Patrick DeHeer
Dr. Zahid Ladha

PLATINUM LEVEL SUPPORTERS ($1,000-$2,499)

Dr. Sandra Raynor
Executive Director Matt Solak

SILVER LEVEL SUPPORTERS ($300-$499)

Dr. Kathleen Neuhoff
Dr. Angie Glynn
Dr. Daniel Miller
Dr. Patricia Moore
Dr. Walt Warren

BRONZE LEVEL SUPPORTERS ($150-$299)

Dr. Brian Damitz
Dr. Chris Grandfield
Dr. Elizabeth Vulanich

PATRIOT LEVEL SUPPORTERS (LESS THAN $150)

Dr. Kent Burress
Dr. Michael Carroll
Dr. Scott Neville
Dr. David Sullivan

PURPOSE: The American Podiatric Medical Association Political Action Committee's purpose is to raise and disburse funds to candidates for Federal office that support the legislative priorities and goals of the podiatric medical profession. IMPORTANT: All amounts are simply suggested amounts. You may contribute or not contribute without concern of being favored or disadvantaged. Occupation/Employer information is required for aggregate annual contributions of more than $200.00 by the Federal Election Campaign Act. Federal election law does not permit corporate contributions to be used for donation to candidates for federal office. Political contributions are not deductible for income tax purposes.

FOOT SUPPORT PAC UPDATE

The Foot Support PAC is a nonprofit, bipartisan fundraising committee through which podiatrists support state candidates who support podiatric medicine's issues before the Indiana General Assembly.

QUICK FACTS

- IPMA Contributors: 6 Members
- IPMA Contribution Member %: 3%
- IPMA Contribution Total: $2,725/$8,000
- IPMA Contribution Goal %: 34%
- IPMA Foot Support PAC Balance: $23,562.85.
- IPMA Advocacy Fund Balance: $3,845.00

PLATINUM LEVEL ($1,000-$2,499)

- Dr. Sandra Raynor

GOLD LEVEL ($500-$999)

- Dr. Nathan Graves
- Dr. Zahid Ladha

SILVER LEVEL ($300-$499)

- Dr. Cathy Coker
- Dr. Wendy Winckelbach

PATRIOT LEVEL (LESS THAN $150)

- Dr. Richard Stanley

Contribute to Foot Support PAC online at www.indianapodiatric.org/political-action.html.

IPAB REPEALED: LEGISLATIVE WINS SHOW POWER OF GRASSROOTS LETTERS

The Independent Payment Advisory Board (IPAB) has been repealed—an action long sought by APMA and other patient and physician groups—as a result of the two-year budget agreement signed into law Friday, February 9.

APMA has always been on common ground with many organizations whose members provide a wide range of services, treatments, and medical technologies to millions of Medicare beneficiaries, in our strong opposition to the IPAB, which was created by the ACA. APMA and its state component societies signed a letter to Congress sent on May 6, 2015, supporting the repeal of the IPAB. APMA previously sent a letter to Congress on February 28, 2012, supporting repeal of the board.

The IPAB would have consisted of officials appointed by the president to essentially assume authority over Medicare, usurping congressional authority over the program. The IPAB was directed to recommend savings for Medicare (beginning in 2014 for implementation in fiscal year 2015) if the per capita growth in Medicare spending exceeded defined target growth rates.

EMPLOYED VS. INDEPENDENT PRACTICE AS A PHYSICIAN

BY HEIDI MOAWAD, MD

One of the most important decisions a doctor makes is whether to take an employed position or to run an independent practice. There are pros and cons to each choice, and the decision rests on factors that relate to personal preference as well as professional survival.

FINANCIAL RISK

Independent physicians take in more financial risk than employed physicians. The investment required to rent or buy clinic space, purchase medical equipment and pay staff salaries is an upfront cost of setting up a medical practice — before any patients are even scheduled, and long before any patient care reimbursement is collected.

Depending on your financial and emotional ability to withstand risk, this may or may not be the right choice for you. More and more doctors are opting to take paid positions instead of adding costs — or debt — to their already extensive educational loans. Yet, some consider the investment of owning a medical business and controlling the profit worth the upfront expenditure and risk.

PAYER NEGOTIATION

As contracts with payers have become more complex than ever throughout the past several years, many doctors consider the prospect — or reality — of negotiating payments for a small practice to be nearly impossible. Sometimes larger nearby healthcare systems are granted preferred provider status, or the reimbursement that smaller practices can negotiate for medical services provides minimal, if any, profit margin with which to run a medical business.

Yet, on the other hand, some small practices and independent physicians are in a position to negotiate for better reimbursement from payers if, for example, the large hospital systems make trade-offs that result in deeply discounting some specialists' services.

THE FINAL WORD ON DECISIONS

Will the office close on government holidays? Are all patients offered same-day appointments? Is it customary to request brand names for some prescriptions? Which days is the procedural suite available for scheduling? These and a multitude of other decisions are more important to some doctors than others.

Employed physicians often have to submit to institutional rules or argue with administration over each detail. Independent doctors usually set their own rules about these details and enjoy the convenience of making their own decisions, while also dealing with negative feedback as a repercussion from those decisions.

EMPLOYEE MANAGEMENT

Some doctors are great bosses. And that is a requirement of running your own practice. Employees, whether other physicians, health care providers or administrative staff, will only work hard if the workplace climate feels right or if the compensation is better than what they can find elsewhere.

If you run your own practice and cannot master people management, then your good staff will leave, and you could be left with mediocre employees for a long time. Yet, many doctors choose the independent route as a way to hire strong workers, compensating well and providing a good work atmosphere that could not be controlled in a larger healthcare system.

STATUS

Some physicians consider self-employment to be the ultimate achievement, while others consider being a staff member of a well-known local or nationality recognized hospital to be validating. In fact, for many doctors who define the meaning of being a successful physician as 1 of these 2, the decision about hospital employment versus self-employment may already be made before finishing residency. As a physician trains, she or he often sets the stage for the best fitting practice by selecting fellowships and preferred locations in the country.

SELF-EMPLOYED VS. EMPLOYED PHYSICIAN

There are many factors to consider when deciding whether to invest in an independent practice or work as an employed physician. The healthcare climate has made it more and more difficult for doctors to remain independent and self-employed — however, many are able to follow that path and succeed.

This article was originally published in MD Magazine *on February 6, 2018. The original article can be found at www.mdmag.com/physicians-money-digest/practice-management/employed-vs-independent-practice-as-a-physician.*

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Hyatt Regency Chicago
Chicago, Illinois

APMA The National
July 12-15, 2018
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Washington, D.C.

IPMA Annual Convention
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