Get Ready for ACFAS 2018

Tim McGraw said it best: Nashville wouldn’t be Nashville without you. Join us for the 2018 ACFAS Scientific Conference, March 22–25, 2018 at the Gaylord Opryland Hotel for an experience like no other. Music City awaits you with a friendly, fun-loving atmosphere, round-the-clock free live performances, world-famous local cuisine and a conference filled with:

- Nonstop clinical sessions, such as Hallux Valgus Honky Tonk, Reconstruction Madness, Ankle Fracture A–Z plus hundreds more
- Exhibits and scientific posters showcasing the latest breakthroughs in foot and ankle surgery
- Special events, including the Premier Connection on opening night and Wrap Party at the iconic Country Music Hall of Fame
- Hands-on cadaveric workshops to send your surgical skills off the charts
- The HUB theater, Annual Job Fair and other all-time conference favorites
- Unlimited opportunities to reconnect with your colleagues

Reserve your hotel room now at acfas.org/nashville and consider coming to Nashville a day early for new preconference workshops and a peek behind the curtain at ACFAS 2018. If you plan to fly Delta when arriving to Nashville on March 20 or 21, use discount code NMR4D when booking your flight at delta.com/meetings or by calling Delta directly.

Submit an Article to JFAS

2018 Board Elections on Horizon

President’s Perspective: I WISH I HAD AN ANSWER...
There seems to be some confusion about the terms podiatrist versus foot and ankle surgeon and what exactly the difference is. Recently, I was in a hospital meeting where we discussed changing our department name to one that better defines what we do in the hospital—the department of Foot and Ankle Surgery. One of my colleagues in another specialty stated that I was not a foot and ankle surgeon—I was a podiatrist. “That is why you went to podiatry school.” I found this irritating because others were defining my profession.

First of all, I did not attend “podiatry school.” There is no such thing! There are colleges of podiatric medicine. Attending a college of podiatric medicine made me a podiatric physician and surgeon. Similarly, doctors who graduate from a college of medicine are allopathic physicians, while doctors who graduate from a college of osteopathic medicine are osteopathic physicians. Being a podiatric physician does not define our profession, it defines our medical degree. Our profession or trade is defined by what we do after our medical education, much the same as our allopathic and osteopathic colleagues. Allopathic and osteopathic physicians do not define themselves by their education. They do not state “I am an allopathic orthopaedic surgeon,” or “I am an osteopathic vascular surgeon.” They simply state their profession: “I am an orthopaedic surgeon.” Why would we be any different?

So, by education we are podiatric physicians. Some of us go on to be podiatrists. Don’t get me wrong, there is nothing wrong with being a podiatrist. These doctors perform a much needed service that no other profession provides. Others, including all ACFAS members, go on to train to become foot and ankle surgeons. We do our residencies in foot and ankle surgery, not in podiatry.

After training, virtually all medical specialties demonstrate competence in their field by becoming board certified. We become board certified in foot surgery and rearfoot and ankle surgery, not in podiatry. No other specialty has a board certification for foot and ankle surgery. The entity that certifies us is the American Board of Foot and Ankle Surgery, and a few years ago, they went through a crucial name change to more accurately define what we do.

Then, after becoming board certified in their field of expertise, doctors join one or more professional societies that provide lifelong education and services and help to advance patient care. We have joined the American College of Foot and Ankle Surgeons. Seventy-five years ago, our founders could have chosen a dozen different names, but they wisely chose the American College of Foot Surgeons. And, we defined our profession even further in 1991 when we became the American College of Foot and Ankle Surgeons.

We do our residencies in foot and ankle surgery, become board certified by the American Board of Foot and Ankle Surgery in foot surgery and rearfoot surgery and become members of the American College of Foot and Ankle Surgeons. If that doesn’t make you a foot and ankle Surgeon, then what does?

Questions for Dr. Rubin? Write him at president@acfas.org.

Laurence G. Rubin, DPM, FACFAS
ACFAS President
Unearth New Surgical Solutions in the Trenches This Spring

Don’t let a complex forefoot injury or deformity case catch you off guard. Join us “In the Trenches” this spring where we will explore practical, Monday-morning solutions for your toughest surgical challenges.

This new seminar in the On the Road regional program series begins on Friday evening with the presentation, “Controversies and Complications,” followed by an open discussion during which you can share your work cases. Expert faculty will lecture on Saturday then guide you through two sawbones labs on osteotomies and the Big 6 Techniques.

You’ll leave the seminar with a renewed ability to:

- identify indications and contraindications for forefoot deformities;
- address complications from forefoot injuries;
- formulate treatment plans; and
- manage cases involving staging principles, positioning and fluoroscopy methods.

Register now at acfas.org/education.

*To be waitlisted for sold-out courses, contact Maggie Hjelm at hjelm@acfas.org.
You Just Submitted an Article to JFAS: What Happens Next?

D. Scot Malay, DPM, MSCE, FACFAS, Editor of The Journal of Foot & Ankle Surgery (JFAS), answers frequently asked questions about what happens between Journal article submission and publication.

What happens to my article after I submit it to JFAS?

**Dr. Malay:** All manuscripts submitted to JFAS go through editorial consideration and peer review, all of which takes place in the Elsevier Editing System (EES). All communications occur between the corresponding author and the editors.

Once a new manuscript is submitted, I read it and consider whether or not it fits the Journal’s content criteria. If I think it is suitable for JFAS in terms of content, I assign it to a section editor who, in turn, invites peers to comment on the report.

The peer review process is blind, and neither the authors nor reviewers know each other’s names or institutions. Editors, on the other hand, are aware of the authors’ and reviewers’ names and institutions. Editors generally invite three or more peers to critically appraise the submission, and our aim is to provide the author with a minimum of two blind peer reviews, along with the section editor’s recommendations and my own critique of the report. Peers are asked to provide their comments within two weeks, and the section editor is asked to make a decision (revise, reject or accept) within 30 days.

What is the turnaround time from article submission to publication?

**Dr. Malay:** On average, it takes about 35 ± seven days to make a decision. The ultimate duration of time between submission and publication, should a manuscript be accepted for publication, varies with the number of revisions that we request and the time that it takes for the author to revise and complete the resubmission process. It takes between two and four months on average for a manuscript to be revised.

Revised manuscripts are reassigned to the original section editor, and the same peer reviewers are asked to review the revised manuscript. Thereafter, the section editor makes another decision as to the disposition of the manuscript, after which I inform the corresponding author of the decision. Once again, our aim is to make this decision within a 30-day period. On average, the articles that we publish in JFAS have gone through two revisions, and it takes between six and nine months from initial submission to acceptance for publication.

How can I track the status of my article?

**Dr. Malay:** Authors can track their submission in the EES, where they can also inquire about the status of their submission. I respond to any inquiries that we receive. Editors and peer reviewers can communicate with one another, but due to the blinding process, authors can only communicate with editors.

What should I do if I do not hear back right away?

**Dr. Malay:** We check our email daily and reply to all author queries within 24 to 48 hours. Authors are instructed to use the EES for all communications related to their manuscript since this online system rigorously logs all activities, including communications, between editors and authors. If you do not hear back right away, we ask that you email us again. Furthermore, authors must designate a corresponding author since this has been shown to be the best way to organize and keep track of communications. This is a standard production process based on many
decades of scientific journal experience. As such, coauthors are advised to communicate with, and through, their corresponding author. Since at any one time we have more than 200 manuscripts in various stages of the reviewing and editing processes, it is necessary that the corresponding author serve as the point person for his or her coauthors.

**What happens to my article after it is accepted for publication in JFAS? Who gets to read it?**

**Dr. Malay:** After a manuscript is accepted for publication, which on average requires two revisions, and after the author approves the page proofs, the article is published online and indexed in the online databases (BioMed, CINAHL, MEDLINE, Scopus, and others). Once that occurs, the report is available to readers as an Article in Press, after which it is published in a print issue of *JFAS*. Immediately prior to publication, and following incorporation of the final revisions, the corresponding author, on behalf of the coauthors, assures that the report has not been submitted or published elsewhere and informs us as to the type of publication process desired. Typically, authors choose to publish their research for free as a traditional subscription article. This means the article is made available only to *Journal* subscribers or to others who pay for access to the article.

If an author chooses to publish an Open Access article, the report is made available online to subscribers and nonsubscribers of *JFAS* worldwide within two to three weeks. This pay-to-publish arrangement gives millions of readers worldwide free, immediate and permanent online access to the article through ScienceDirect. ACFAS members receive a 50 percent discount on the Open Access publication fee.

For more information on *JFAS* or to submit your article, visit [acfas.org/jfas](http://acfas.org/jfas).
Residency directors, do you plan to attend the 2018 ACFAS Scientific Conference March 22–March 25 in Nashville? Then come a day early for the fourth annual Residency Directors Forum, cohosted by the Council of Teaching Hospitals (COTH), on March 21 from 1:30–5:30pm at the Gaylord Opryland Hotel.

Residency program codirectors and faculty are also invited to attend, with up to two attendees per program. And for the first time, chief residents are invited to the Forum, but they must be accompanied by their residency’s program director.

Space is limited and there is no on-site registration, so please register early. Registration deadline is March 2, 2018.

This invitation-only event will address:

- updates from COTH, the American Association of Colleges of Podiatric Medicine, the Council on Podiatric Medical Education (CPME), the Podiatry Residency Resource (PRR) as well as the Boards (American Board of Foot and Ankle Surgery and American Board of Podiatric Medicine);
- the ins and outs of residency program funding;
- new changes and improvements to the PRR logging process;
- CPME’s latest efforts to streamline program site visits;
- a follow-up discussion on the dos and don’ts of social media for residents;
- graduating students’ readiness for residency and efforts to raise the bar;
- the DPM Mentors Network, which aims to strengthen the future of the profession; and
- grassroots residency program collaboration and ACFAS Regional support of residency programs.

Registration is open until March 2, 2018! Visit acfas.org/rdc for full session details and to download the registration form.
Come to Nashville a Day Early for Special Preconference Workshops

Every great performance starts with a great opening act. Join us at the Gaylord Opryland Hotel in Nashville on Wednesday, March 21, the day before ACFAS 2018 officially begins, for three new preconference workshops worthy of a standing ovation. Choose from:

**Coding and Billing for the Foot and Ankle Surgeon**  
(7:30am–5:30pm, 8 CE contact hours)  
Gain no-nonsense solutions to maximize your surgical billing processes and increase your reimbursement.

**Tendon Transfers: Common to Complex**  
(7:30am–Noon, 4 CE contact hours, includes wet lab)  
Master several tendon transfer techniques to better manage common deformities.

**Common Corrective/Realignment Osteotomies**  
(Noon–5pm, 4 CE contact hours, includes wet lab)  
Perform common forefoot and rearfoot osteotomies step by step with expert faculty.

Registration details for these special programs will be available at acfas.org/nashville soon—stay tuned!
ACFAS Board Nominees Announced

After careful review of applicants to serve on the ACFAS Board of Directors, the Nominating Committee recommends these four Fellows for two positions in the upcoming electronic election:

- Eric A. Barp, DPM, FACFAS
- George T. Liu, DPM, FACFAS
- Roya Mirmiran, DPM, FACFAS
- Eric G. Walter, DPM, FACFAS

Two three-year terms will be filled by election. Candidate profiles and position statements will be posted at acfas.org/nominations on December 15. Eligible voters may cast one or two votes on their ballot. Regular member classes eligible to vote are Fellows, Associates, Emeritus and Life Members. Individuals who intend to nominate by petition must notify ACFAS by November 30, and petitions are due no later than December 23.

Online voting will be conducted January 7-22, 2018. All eligible voters will receive an email with special ID information and a link to the election website in advance. After logging in, members will first see the candidate biographies and position statements, followed by the actual ballot. Eligible voters without an email address will receive paper instructions on how to log in to the election website and vote. There will be no paper ballots.

The 2017 Nominating Committee included ACFAS Fellows Sean Grambart, DPM, Chair; Georgeann Botek, DPM; Tony Kim, DPM; Javier La Fontaine, DPM; Alan MacGill, DPM; Laurence Rubin, DPM; and Monica Schweinberger, DPM.

2018–2019 Board Officers Elected

The Board of Directors elected its officers for 2018–2019 pursuant to the College’s bylaws. Terms will commence at the ACFAS 2018 Scientific Conference March 22–25 in Nashville.

President:
John S. Steinberg,
DPM, FACFAS

President-Elect:
Christopher L. Reeves,
DPM, MS, FACFAS

Secretary-Treasurer:
Scott C. Nelson,
DPM, FACFAS

Immediate Past President:
Laurence G. Rubin,
DPM, FACFAS
Special Task Force to Examine Speaker Selection Criteria

As the College’s Annual Scientific Conference continues to grow in size and attendance, it is more important than ever to ensure that speaker selection is based on:

- competence;
- expertise;
- firsthand experience;
- platform skills; and
- relevance.

Speaker rotation also helps bring fresh, new talent and perspectives to the podium each year, and attendee evaluations always request more new faces.

ACFAS follows “duty of loyalty” policies that require committees to put the interest of all members ahead of personal agendas. This includes discouraging members from lobbying committee chairs or members to avoid being swayed by self-interests.

The ACFAS Board recently appointed a special task force to examine the College’s speaker selection criteria as it relates to its duty of loyalty policies principle. A new speaker selection criteria will be in place by February 2018 for use starting in 2019. The task force will also study other national medical societies’ speaker selection procedures for ideas to use in the College.

To learn more about the task force, contact ACFAS Executive Director J.C. “Chris” Mahaffey at mahaffey@acfas.org.
Save the Date: Take a New Look at Practice Building Webinar

Wednesday, January 17, 2018 | 8pm ET/7 pm CT

Do you struggle with generating referrals? Attracting new patients? Cutting through the clutter to build your practice? Well, with the new year approaching, it’s the right time to think about setting practice growth goals.

To ensure you have the tools you need to make practice growth a reality, we’re hosting the Take a New Look at Practice Building webinar on Wednesday, January 17, 2018 at 8pm ET/7 pm CT.

The webinar will provide insight on how to leverage tools from the Take a New Look at Foot & Ankle Surgeons campaign to generate or strengthen referrals to your practice. Presenters Christopher L. Reeves, DPM, FACPAS; Amber M. Shane, DPM, FACPAS; and John S. Steinberg, DPM, FACPAS will share their own experiences networking with family physicians, nurse practitioners and diabetes educators at national conferences and will discuss the importance of proactive relationship building to encourage referrals.

In addition, Melissa Matusek, ACFAS director of Marketing and Communications, will speak about how to use the resources in the ACFAS Marketing Toolbox to attract new patients to your practice through traditional media outreach, social media and community relations, just to name a few.

Make 2018 the best year for your practice by joining the webinar in January. Watch for more information and RSVP details!
When nurse practitioners (NPs) and foot and ankle surgeons work in harmony to treat patients, outcomes improve and patients thrive. But how exactly do NPs and foot and ankle surgeons collaborate on a daily basis in patient care?

Sean T. Grambart, DPM, FACFAS, of Carle Physician Group in Champaign, Illinois, works with several NPs in his practice, and based on his experience, NPs and foot and ankle surgeons are collaborating more than ever, especially as the role of NPs continues to expand in different departments. “We work together on everything from trauma cases in the emergency department, to infections and trauma in inpatient hospital settings to flatfoot deformities and bunions in regular office patients,” he explains.

NPs and foot and ankle surgeons typically take a team approach to treating patients, particularly those with multiple comorbidities, such as a patient living with diabetes, renal disease and peripheral vascular disease. “A team approach gives these patients the best chance of an optimal outcome,” notes Dr. Grambart.

Since NPs practice independently, they help foot and ankle surgeons better manage their patient loads and in turn free up time so other duties can be completed. For example, Dr. Grambart’s NPs assist with postoperative patients and nonsurgical fracture care. He can put a patient on an NP’s schedule if needed but also strives to make himself available to the NPs if he has time in between patients.

How foot and ankle surgeons and NPs decide to delineate or divide their responsibilities depends largely on NPs’ training and surgical skills. Dr. Grambart maintains that surgeons must take the time to train their NPs properly to help them develop their surgical technique and feel comfortable treating postoperative patients. “Highly trained NPs are a great asset to any practice,” he attests.

While NPs and foot and ankle surgeons often enjoy healthy and productive working relationships, challenges can arise. In Dr. Grambart’s opinion, not understanding each other’s scope of practice stands as the biggest roadblock between NPs and foot and ankle surgeons. He says the best way to resolve this is for NPs and foot and ankle surgeons to openly communicate what each of their specialties does and what they offer to patients. This open communication also strengthens the partnership between the foot and ankle surgeon and NP.

Dr. Grambart considers his working relationship with the NPs in his practice a win for his patients. “Collaborating with NPs has resulted in better patient care,” he says. “That’s the most important thing.”

Visit TakeANewLook.org for more on how the College is spreading the word among NPs and other providers about foot and ankle surgeons’ specialized training.

“We work together on everything from trauma cases in the emergency department, to infections and trauma in inpatient hospital settings to flatfoot deformities and bunions in regular office patients.” — Sean T. Grambart, DPM, FACFAS
New Study Demonstrates the Economic Costs & Medicare Policy Implications of Chronic Wounds

With quality measure-based payment models now driving Medicare reimbursement under the Medicare Access and CHIP Reauthorization Act (MACRA), foot and ankle surgeons, wound care practitioners and other healthcare providers have few reportable quality measures relevant to wound care.

A study published in the International Society for Pharmacoeconomics and Outcomes Research’s Value in Health journal shows the full burden and cost of wound care in the U.S. Medicare population, highlighting the need for health policymakers at the U.S. Centers for Medicare and Medicaid Services (CMS) to develop more appropriate quality measures, episode of care measures and reimbursement models for wound care.

The study, “An Economic Evaluation of the Impact, Cost and Medicare Policy Implications of Chronic Nonhealing Wounds,” analyzed 2014 Medicare data and determined the cost of chronic wound care for Medicare beneficiaries in aggregate, by wound type and by setting. The findings show:

- Chronic nonhealing wounds affect nearly 15 percent of Medicare beneficiaries (8.2 million).
- A conservative estimate of the annual cost is $28 billion when the wound is the primary diagnosis on the claim. When the analysis included wounds as a secondary diagnosis, the cost for wounds is conservatively estimated at $31.7 billion.
- Surgical wounds and diabetic foot ulcers drove the highest total wound care costs (including cost of infections).
- On an individual wound basis, the most expensive mean Medicare spending per beneficiary was for arterial ulcers followed by pressure ulcers.
- Hospital outpatient services drove the greatest proportion of costs, demonstrating a major shift in site-of-service costs from hospital inpatient to outpatient settings.
- Surgical infections were the largest prevalence category, followed by diabetic wound infections.

This documentation of the economic impact of nonhealing wounds can be meaningful from a policy perspective moving forward. “The true burden of wound care to Medicare has remained relatively hidden and has not been a focus from a public policy standpoint in the United States. We are hopeful that documenting the significant economic cost and impact of chronic wounds can influence priorities for federal research funding in this space and for innovative payment approaches by CMS, including quality and performance measures within MACRA,” noted lead study author Samuel Nussbaum, MD, Schaeffer Center for Health Policy and Economics, University of Southern California.

National quality measures have not been developed for use under MACRA’s Merit-Based Incentive Payment System that are relevant to the broad spectrum of wound care. With quality measure-based payment models driving Medicare reimbursement

“The true burden of wound care to Medicare has remained relatively hidden and has not been a focus from a public policy standpoint in the United States.” — Samuel Nussbaum, MD
“CMS needs to recognize the cost and prevalence of chronic wounds in the development of chronic care models and episodes of care.” — Caroline Fife, MD

under MACRA, this is a problem for practitioners. “CMS needs to recognize the cost and prevalence of chronic wounds in the development of chronic care models and episodes of care. Chronic wounds can’t be forgotten about if we want to drive better health outcomes and smarter wound care spending,” said coauthor Caroline Fife, MD, medical director of CHI St. Luke’s Hospital (The Woodlands, Texas) and executive director of the U.S. Wound Registry.

The study was funded by the Alliance of Wound Care Stakeholders, an association of clinician and medical specialty societies focused on promoting quality care and access to products and services for people with wounds and the providers who treat them. ACFAS is a member of the Alliance.
Watch Your Mailbox for Your Dues Reminder

ACFAS has mailed hardcopy membership dues reminders for the 2018 calendar year to all Associate and Fellow members. Pay your dues online at acfas.org/paymydues or by mail or fax once you receive your reminder. Payment is due by December 31, 2017.

Visit the ACFAS Member Center at acfas.org/members to learn how to make your ACFAS member benefits work for you.

In Memory

Robert G. Levine, DPM, FACFAS
Louisville, KY

Merton Glick, DPM, FACFAS
North Palm Beach, FL

David C. Kraatz, DPM, FACFAS
Collingswood, NJ

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